Supreme Court, U. S.
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APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,

Petitioners

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,

Respondents

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, ET AL.,

Petitioners

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,

Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR CERTIORARI IN 74-1110 FILED MARCH 6, 1975
PETITION FOR CERTIORARI IN 74-1124 FILED MARCH 8, 1975
CERTIORARI GRANTED AND CASES CONSOLIDATED MAY 19, 1975

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CIVIL DOCKET

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

C.A. No. 1378-71

EASTERN KENTUCKY WELFARE, ET AL

vs.

JOHN CONNALLY, ET AL

Attorneys:
Anthony Z. Roisman
1712 N Street, N.W.
Washington, D.C. 20036
Marilyn G. Rose
1751 N St., N.W. 20009

PARTIES

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION

CALIFORNIA WELFARE RIGHTS

NATIONAL TENANTS ORGANIZATION

ASSOCIATION OF DISABLED MINERS AND WIDOWS

HEALTH, EDUCATION, ADVISORY TEAM, INC.

HENRY AND CAROLYN BLOCK

VIRGINIA STEPHENS

TORA MAE COLLINS

ARTIE TACKETT

BALLARD CABLE

JOEY JAY BLEVINS

MARY AND JAY BLEVINS

ROSEZELLA COOK

SHIRLEY LAMPTON

MONICA HUNTER

vs

1. JOHN CONNALLY

2. HAROLD T. SWARTZ

Jack B. Teplitz
Dept. of Justice

CIVIL DOCKET

DATE	PROCEEDINGS
1971	
	Deposit for cost by
July 12	Complaint, appearance. filed
July 12	Summons, copies (4) and copies (4) of Complaint issued; all served on 7-13.
July 12	Certificate of service. filed
Sept. 13	Stipulation extending time for defts. to respond to 11-8-71. (Fiat) Jones, J.
Nov. 5	Motion of defts. for extension of time to answer or otherwise plead; c/m 11-5-71; Appearance of Jack B. Teplitz. filed
Nov. 12	Order extending time to 11-18-71 within which defts. may answer or otherwise respond to the complaint. (N) Parker, J.
Nov. 18	Motion of defts. to dismiss; P&A's; attachment A; c/m 11-18-71; M.C. filed

DATE	PROCEEDINGS
1971	
Dec. 2	Motion of pltfs. for extension of time; P&A; c/m 11-29-71; M.C. filed
Dec. 13	Order extending time for pltfs. to respond to defts. motion to dismiss to 12-17-71. (N) Parker, J.
Dec. 16	Response of pltfs. in opposition to defts. motion to dismiss; c/m 12-10-71. filed
Dec. 22	Correction sheet (erratum) by pltfs; c/m 12-20-71. filed
1972	
Jan. 10	Change of address of Marilyn G. Rose, co-counsel for pltfs; c/m 1-5-72. filed
Jan. 27	Supplemental memorandum of pltfs. in response to defts. motion to dismiss; c/m 1-25. filed
Apr. 28	Motion of deft. to dismiss, denied. Order to be presented. Parker J.
May 10	Order denying motion of defts. to dismiss complaint. (N) Parker J.
May 26	Answer of defendants to complaint; c/m 5-25.
July 24	Status report. Case will be certified to pretrial on 12-1-72. Parker J.
1973	
Apr. 10	Motion of pltfs for summary judgment against defts; P & A index; statement; index of exhibits; exhibits 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14-A, B, c, d, e, f, g, h, i, j, k, k-7, 15; c/m 4/10/73 M.C.
Apr. 12	Motion of defts for additional time to respond to motion for summary judgment; P & A; c/m 4/12/73. M.C.
Apr. 17	Motion of pltf's for leave to file supplemental affidavit P & A. Exhibit. c/m 4/16. M.C.

DATE	PROCEEDINGS
1973	
Apr. 17	Order allowing defts. until 5-25-73, to respond to pltfs. motion for summary judgment. (N) Parker, J.
Apr. 23	Motion of pltf for leave to file supplemental affidavit, granted. (fiat) (N) Parker, J.
May 29	Stipulation extending time within which defts may file response to pltfs motion for summary judgment to 6-8-73 (N) Parker, J.
June 7	Change of address of Anthony Z. Roisman to 1712 N Street, N:W.
June 27	CROSS-MOTION of defts for summary judgment; P & A; statement; c/m 6/27/73. M.C.
July 12	OPPOSITION by pltffs. to defts' cross-motion for summary judgment; appendix A, B, and C; c/s 7/12/73.
July 20	OBJECTIONS by defts. to pltffs. statement of material facts; c/m 7/20/73.
Aug. 6	MOTION of pltffs. for sanctions; exhibit 1—appendix A and B; P & A's; c/m 8-2-73.
Aug. 8	MOTION of defts. for leave of Court to file affidavits and letter; P & A; exhibits (10) c/s 8-7
Aug. 8	MOTION of defts. for leave of Court to file statement of genuine issues; P & A; exhibit. c/m 8-7
Aug. 8	MEMORANDUM of defts. in opposition to pltfs' motion for sanctions against defts, award of attorneys' fees, striking of defts' objections to pltfs' statement of material facts, and finding that there is no dispute of material facts. c/s 8-8

DATE	PROCEEDINGS
1973	
Aug. 10	SECOND motion of pltfs. for sanctions against defts, and their attorneys, award of attorneys' fees, opposition to motions for leave to file statement of genuine issues and affidavits and letter, and alternative finding that whether or not such affidavits and letter are considered, there is no dispute of material facts; P&A. c/s 8-10
Aug. 15	MOTION of pltffs. for summary judgment taken under advisement. Motion of defts. for summary judgment taken under advisement. Each to submit proposed findings of fact, conclusions of law and proposed order by 9-17-73. (Rep: G. Nevitt) Parker, J.
Aug. 22	CITATIONS by defts. of cases and other authorities; attachment (1); c/m 8/22/73.
Sept. 17	PROPOSED Findings of Fact & Conclusions of Law by defts. c/m 9-17.
Sept. 18	PROPOSED Findings of Fact & Conclusions of Law by pltfs. c/m 9-13
Dec. 20	MEMORANDUM OPINION denying cross-motion of deft. for summary judgment and granting motion of pltfs. for summary judgment. (N) Parker, J.
1974	
Jan. 9	OBJECTIONS of defts. to proposed order of pltfs.; attachment; c/m 1-9-74.
Jan. 14	APPLICATION of American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; P&A's; affidavit of John E. Sullivan; c/m 1-11-74.

DATE	PROCEEDINGS
1974	
Jan. 21	OPPOSITION of pltfs. to the application by the American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; c/m 1-21-74.
Jan. 22	RESPONSE by pltfs. to objections of defts. to proposed order of pltfs.; appendix A; appendix B; c/s 1-14-74.
Jan. 25	RESPONSE of the American Hospital Association to opposition by pltfs. to the application of The American Hospital Association to intervene as amicus curiae and for reconsideration of the Court's memorandum opinion of 12-20-73; c/m 1-24-74.
Jan. 28	MEMORANDUM ORDER denying leave to intervene by American Hospital Association as amicus curiae. (N) Parker, J.
Jan. 29	ORDER directing entry of a judgment in favor of pltfs. (N) Parker, J.
Feb. 6	MOTION by deft for stay of enforcement of the injunctive relief provisions of the Court's order entered on January 29, 1974; P & A's; c/m 2-6-74.
Feb. 15	OPPOSITION by pltfs. to defts. motion for stay of enforcement of the injunctive relief provisions of the Court's Order; c/m 2-15-74.
Feb. 21	NOTICE of change of address of counsel for pltfs.; c/m 2-8-74; CD/N
Feb. 21	ORDER denying motion of defts. to stay enforcement of the Order entered on 1-29-74. (N) Parker, J.

DATE	PROCEEDINGS
1974	
Feb. 22	NOTICE of appeal by defts. from ORDER of 1-29-74. Copies mailed to Anthony Roisman and Marilyn G. Rose; c/m 2-22-74.
Feb. 26	PRELIMINARY record delivered to USCA; receipt acknowledged.
Mar. 6	NOTICE by counsel Laurens H. Silver of change of address to 311 California St., Suite 301, San Francisco, California 94104
Mar. 14	COPY of SUPPLEMENTAL memorandum by defts. in support of motion for stay; c/s 3-14-74.
Mar. 26	LETTER from defts. attorney re: copy of second supplementary memorandum in support of motion to stay filed in U.S. Court of Appeals; exhibit.
Apr. 1	PROGRESS REPORT by defts. taken to implement this Court's Order of 1-29-74; attachments (2); c/m 4-1-74.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PARKER, J.

[Filed Jul. 21, 1971, James F. Davey, Clerk]
Civil Action No. 1378-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION
c/o Mrs. Eula Hall
Craylor, Kentucky

CALIFORNIA WELFARE RIGHTS ORGANIZATION
1442 E. Florence Avenue
Los Angeles, California

NATIONAL TENANTS ORGANIZATION
425 - 13th Street, N.W.
Washington, D.C.

ASSOCIATION OF DISABLED MINERS AND WIDOWS
Madison, West Virginia

HEALTH, EDUCATION, ADVISORY TEAM, INC.
440 Madison Street
Fairmont, West Virginia

HENRY AND CAROLYN BLOCK
729 E. Mabel Street
Tucson, Arizona

VIRGINIA STEPHENS
Harold, Kentucky

TORA MAE COLLINS
Tram, Kentucky

ARTIE TACKETT
Harold, Kentucky

BALLARD CABLE
Harold, Kentucky

JOEY JAY BLEVINS, a minor,
by his parents and guardians
MARY AND JAY BLEVINS
Honaker, Kentucky

ROSEZELLA COOK
2652 Alvar Street
New Orleans, Louisiana

SHIRLEY LAMPTON
2636 Mazant Street, Apt. E
New Orleans, Louisiana, and

MONICA HUNTER
416 N. Viller Street
New Orleans, Louisiana

On their own behalf and on behalf of
all other persons similarly situated,
Plaintiffs,

vs.

JOHN CONNALLY, as Secretary of the Treasury of the United States, Department of the Treasury, Washington, D.C., and

HAROLD T. SWARTZ, as Acting Commissioner of Internal Revenue, Internal Revenue Service, Washington, D.C.
Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. PLAINTIFFS invoke the jurisdiction of this Court under 28 U.S.C. 1331, 1340, and 1361, 28 U.S.C. 2201 and 2202 and 5 U.S.C. 702 and 703. The value of the rights asserted exceeds $10,000 for each individual PLAINTIFF.

2. This is an action for declaratory and injunctive relief, declaring the rights of poor people to receive services without charge from private hospitals which receive federal tax exemptions as "charitable" institutions under 28 U.S.C. 501(c)(3), and restraining and enjoining DEFENDANTS from granting or continuing to grant tax exemptions to private hospitals which refuse admission and free services to persons unable to pay, in contravention of the Internal Revenue Code of 1954. PLAINTIFFS also seek to compel DEFENDANTS to institute proceedings leading to the revocation of the tax exempt status of private hospitals which deny admission and service to persons unable to pay, to revoke a general ruling entitling said hospitals to tax exempt status as "charitable", and to collect all taxes due and owing because of said illegal designation.

3. Monetary damages are inadequate and no adequate remedy at law is available to individual PLAINTIFFS and others similarly situated who have suffered and will continue to suffer irreparable harm and the threat of irreparable harm from the action of DEFENDANTS complained of herein.

PARTIES

4. PLAINTIFF, EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, is a nonprofit corporation organized under the laws of Kentucky whose members include low income persons primarily residents of Floyd County, Kentucky with a chapter in Pike County, Kentucky. EKWRO was organized to represent and promote the social welfare of recipients of public assistance programs, Social Security and Medicaid and of other low income persons in the eastern section of Kentucky, including Floyd and Pike Counties, in a broad range of activities, including, *inter alia*, the needs and

interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are the beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

5. PLAINTIFF, CALIFORNIA WELFARE RIGHTS ORGANIZATION, is an unincorporated association organized to represent and promote the social welfare of recipients of public assistance programs and Medi-Cal and of other low income persons in the State of California in a broad range of activities, including, *inter alia*, the needs and interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

6. PLAINTIFF, NATIONAL TENANTS ORGANIZATION, is a nation-wide nonprofit corporation organized to represent and promote the social welfare of its memberships, which is almost entirely low income tenants, in a broad range of activities including *inter alia*, the needs and interests of such persons in obtaining health and hospital care and services. Its members and the persons it represents are intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

7. PLAINTIFF, ASSOCIATION OF DISABLED MINERS AND WIDOWS, INC., is a nonprofit corporation representing approximately 4,000 disabled miners and widows of miners who reside primarily in the Appalachian coal field states of West Virginia, Kentucky, Tennessee, Virginia, Ohio, Pennsylvania, and Maryland with scattered memberships in other states. It represents its members in a range of social health and welfare purposes including their special health and hospital needs.

The disabled miners in its memberships all have serious health problems which range from pneumoconiosis (black lung) to traumatic work connected injuries, to heart and other problems which require frequent health services. The income of each member is derived principally from social security disability benefits and/or workmen's compensation which places them below the OEO poverty guidelines. The members lack private health insurance, health benefits under employment and union contracts, Medicaid, and the means to pay for hospital services, and are persons intended to be protected by, and are beneficiaries of the "charitable" tax provisions of the Internal Revenue Code of 1954.

8. PLAINTIFF, HEALTH, EDUCATION, ADVISORY TEAM, INC., is a nonprofit corporation in Marion County, West Virginia, with 2,000 members, organized and funded under a Department of Public Health grant to promote the access of poor people to health care services. Its members and the persons it represents are intended to be protected by, and are the beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

9. Individual PLAINTIFFS HENRY AND CAROLYN BLOCK, VIRGINIA STEPHENS, TORA MAE COLLINS, ARTIE TACKETT, BALLARD CABLE, JOEY JAY BLEVINS, a minor, by his parents and guardians, MARY AND JAY BLEVINS, ROSEZELLA COOK, MONICA HUNTER and SHIRLEY LAMPTON, are citizens of the United States and of the States in which they reside. They are poor people, the sole income for them and their families being principally derived from public assistance, and/or Social Security Survivor Benefits, and/or minimal employment. All individual PLAINTIFFS and their families subsist below the poverty income levels set by the U.S. Department of Labor and the poverty guidelines of the Office of Economic Opportunity. They all suffer from, or have suffered from, various medical conditions requiring health and hospital services and are persons intended to be protected by, and are beneficiaries of, the "charitable" tax provisions of the Internal Revenue Code of 1954.

10. The organization PLAINTIFFS sue on behalf of their members. Each individual PLAINTIFF sues on her or his own behalf and on behalf of all other persons similarly situated as alleged hereinafter. This is a proper class action under Rule 23, Federal Rules of Civil Procedure. The class is so numerous that joinder of all members of the class is impracticable; the claims of the individual PLAINTIFFS are typical of the claims of the class; and the named PLAINTIFFS will fairly and adequately protect the interests of the class. The DEFENDANTS have acted and have refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief with respect to the class as a whole.

11. DEFENDANT JOHN CONNALLY is Secretary of the Treasury of the United States and has his principal place of business in Washington, D.C. DEFENDANT HAROLD T. SWARTZ is Acting Commissioner of Internal Revenue and has his principal place of business in Washington, D.C. Both DEFENDANTS have the responsibility and authority to administer and enforce the Internal Revenue Code of 1954.

STATEMENT OF FACTS

12. The Internal Revenue Code of 1954 provides certain tax exemptions and benefits for institutions classified under its provisions as "charitable", to wit: institutions which qualify as charitable are exempted from payment of federal income taxes by virtue of 26 U.S.C. 501(c)(3); contributions to such institutions are deduc-

tible from gross income on individual and corporate income tax returns by virtue of 26 U.S.C. 170(a) through (c); such institutions and donors to such institutions are also eligible for other federal tax benefits and advantages under Sections 642(c), 2055, 2106(a)(2) and 2522 of 26 U.S.C.

13. Upon information and belief, throughout the United States there are approximately 3500 private hospitals which claim eligibility as "charitable" under these provisions, file the pertinent forms claiming such eligible status, and have been determined as such by DEFENDANTS or their agents. The amount of monies which otherwise would be taxable as income of such hospitals or which otherwise could not be deducted from taxable income by donors to such hospitals is substantial. In fiscal 1969 alone these hospitals have received $2.3 billion from charitable contributions.

14. The consistent legislative history relevant to Section 501(c)(3) and its predecessors as well as the commonly accepted definition establishes that "charitable" means "relief of the poor." The Internal Revenue Service has consistently included in its regulations a definition of the term "charitable" to mean "relief of the poor." Since 1940 the Internal Revenue Service has litigated before Federal and Tax Courts the issue of the tax exempt status of private hospitals and claimed that private hospitals are not eligible for such status if they refused services to persons in need of hospital care but unable to pay. In 1956 the Internal Revenue Service issued Revenue Ruling 56-185 that stated that in order for a hospital to qualify for tax benefits as "charitable",

> ". . . it must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who

> are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."
>
> (Rev. Ruling 56-185, Int. Rev. Bull. 1956)

15. Attempts by private hospitals and/or their agents to have the Internal Revenue Code of 1954 amended to give special tax exempt status to hospitals without regard to free service to persons unable to pay have been rejected by Congress. A recent attempt occurred during the consideration of the Tax Reform Act of 1969. A provision which would have conferred upon hospitals tax exempt status without regard to "charitable" service was set forth in the House bill forwarded to the Senate in August 1969, but the Senate Finance Committee rejected the provision, indicating that it wanted to study the issue in context of its review of the Medicare (42 U.S.C. 1395) and Medicaid (42 U.S.C. 1396) programs. The House bill was conformed to the Senate bill, with the provision deleted, in conference in December 1969. The Tax Reform Act of 1969 was promulgated without such a provision.

16. While the Senate Finance Committee was still considering the issue, the then-Commissioner of Internal Revenue, on October 8, 1969, without a notice of proposed regulations, without a public hearing, and without congressional approval, engaged in legislative action and reversed the historically consistent and lawful interpretation of the word "charitable" in the Internal Revenue Code and issue a ruling that hereinafter the Internal Revenue Service would grant the benefits of the tax exempt provision of the Code to hospitals although said hospitals required that all persons as a condition of admission must be able to pay the cost either directly or through third party reimbursement for hospital services. (Rev. Ruling 69-545, 1969 Cum. Bull.). Despite the subsequent Senatorial disapproval and deletion from the Tax Reform Act of 1969, the DEFENDANTS have not reverted to the historically accepted position.

17. On information and belief throughout the United States private hospitals have been given and continue to receive and enjoy tax exempt status and other benefits under the charitable tax provisions of the Internal Revenue Code of 1954 although they refuse to admit and give services to indigent and medically indigent persons in need of hospital care, and/or admit and thereafter sue and garnish wages of indigent and medically indigent persons in need of hospital care, and/or require either private health insurance or cash deposits as a condition of admission, and/or refuse to admit without a cash deposit patients eligible for Medicaid (governmental health program for public assistance recipients and categorically related persons, 42 U.S.C. § 1396).

18. Persons who are members of and are represented by the organization PLAINTIFFS, and individual PLAINTIFFS and the class they represent, need hospital services but reside in communities in which the private hospitals engage in the practices described in

paragraph 17 herein, and thereby are denied services at said private hospitals which receive and enjoy tax exempt status and other benefits under the charitable tax provisions of the Internal Revenue Code of 1954. The circumstances described in paragraphs 19, 20, and 21 herein documents these practices and the results of these practices.

19. (a) Individual PLAINTIFFS ROSEZELLA COOK, MONICA HUNTER, and SHIRLEY LAMPTON are residents of New Orleans, Louisiana.

(b) PLAINTIFF COOK is a 34 year old Mother of six minor children. The family's sole support is represented by a $73 monthly public assistance check; public assistance also pays $160 a month for a full time housekeeper since PLAINTIFF COOK is too ill to take care of her house and children and needs full time care herself. In June 1970, PLAINTIFF COOK attempted to be admitted to METHODIST HOSPITAL, in New Orleans, but was denied admission because she did not have money needed as a deposit before examination and METHODIST HOSPITAL does not participate in the Medicaid program for which PLAINTIFF COOK is eligible. On various occasions during the following months, specifically September, October, and November, 1970, PLAINTIFF COOK attempted to get admitted at CHARITY HOSPITAL OF LOUISIANA AT NEW ORLEANS (hereinafter CHARITY HOSPITAL), but because of lack of available beds, PLAINTIFF COOK was given only outpatient treatment although a resident on the CHARITY HOSPITAL staff recommended that her medical condition necessitated inpatient treatment. Not until February 1971 was PLAINTIFF COOK admitted for treatment, for the same condition and with the same symptons existing since July 1970.

(c) PLAINTIFF HUNTER is a widow, with four minor children. Her sole monthly income is $147, primarily from Social Security Survivor Benefits. Her income is presently "too high" to qualify her for public assistance, and consequently for Medicaid, under the Louisiana public assistance program. In June 1970, PLAINTIFF HUNTER attempted to get examined and treated at METHODIST HOSPITAL and at HOTEL DIEU HOSPITAL in New Orleans, but at both hospitals was denied examination and treatment for the stated reasons that the hospitals only treated "private patients", that she lacked the money for a deposit, and that the hospitals would not recognize Medicaid under which she was then eligible. Her outpatient treatment at CHARITY HOSPITAL has not relieved her pains, and she believes that she needs extensive tests to determine her condition and the appropriate treatment.

(d) PLAINTIFF LAMPTON is a 30 year old Mother of seven children; the sole family income is derived from a $137 monthly payment under public assistance. She is eligible for coverage under the Medicaid program. In December 1965-January 1966, she was diagnosed at CHARITY HOSPITAL as having kidney problems, but was not admitted as an inpatient. In February 1966, the condition was diagnosed at CHARITY HOSPITAL as having caused permanent damage to her kidneys. Her kidney ailments have persisted until this time. In July 1970, suffering from abdominal pains she went to CHARITY HOSPITAL on two occasions, on the second of which she was given some drugs. She was not admitted as an inpatient. She then went to MERCY HOSPITAL in New Orleans to seek an examination and treatment for her condition. She was told that she needed a private physician, but if she had sufficient money, a physician would be called for her. MERCY HOSPITAL does not participate in the Medicaid pro-

gram. Being without money she left MERCY HOSPITAL. She has continued to suffer pains and swelling in her abdominal area.

(c) CLIFFORD BREAUX was a 57 year old resident of New Orleans who died of congestive heart failure on June 24, 1970. On or about May 1, 1970, a staff physician of OCHSNER FOUNDATION HOSPITAL, who was BREAUX's private physician, examined him and recommended him for hospital admission, but noted that he did not have the $200 for admission into OCHSNER FOUNDATION HOSPITAL and stated he would recommend his admission into CHARITY HOSPITAL. On five occasions between early May and June 8, 1970 CLIFFORD BREAUX and his family attempted to get him admitted into CHARITY HOSPITAL but were unsuccessful because of lack of available beds. On May 29 the intern on the Admit desk recommended his immediate admission but he was not admitted. On June 10 and June 11 his family attempted to obtain admittance for him at OCHSNER FOUNDATION HOSPITAL, TOURO INFIRMARY, and FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY, but was told by staff physician or admitting personnel that they needed to pay a deposit to be admitted. On June 11 his family borrowed $200 and he was admitted into OCHSNER FOUNDATION HOSPITAL upon the payment of the $200 as a deposit. He died in OCHSNER, 13 days after admission, and more than seven weeks after an OCHSNER staff physician had first recorded his need for immediate hospitalization.

(f) METHODIST HOSPITAL, HOTEL DIEU HOSPITAL, MERCY HOSPITAL, OCHSNER FOUNDATION HOSPITAL, TOURO INFIRMARY, and FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY are private nonprofit hospitals in New Orleans which require deposits ranging from $35 for outpatient treat-

ment through $200 to $400 for inpatient treatment prior to admission, and do not participate in the Medicaid program; these hospitals refuse to examine, admit, and/or treat indigent persons seeking hospital services. These practices are common among the private, nonprofit hospitals in the metropolitan New Orleans area.

FLINT GOODRIDGE HOSPITAL of DILLARD UNIVERSITY and one other private nonprofit New Orleans hospital, SARA MAYO HOSPITAL, which claim that they maintained outpatient clinics for medically indigent persons prior to 1970, closed such clinics in early 1970 (shortly after the issuance of Revenue Ruling 69-545); these hospitals also do not participate in the Medicaid program.

TOURO INFIRMARY maintains a reduced-cost clinic for the medically indigent, but persons below a certain income, which corresponds approximately with the OEO poverty guidelines, are not eligible. These private nonprofit hospitals enjoy tax exempt status as determined by DEFENDANTS under Section 501(c)(3) of the Internal Revenue Code of 1954, and substantial donations to these hospitals for the construction of new facilities have been deducted by donors, and further donations shall be deducted. On information and belief such donations have and shall amount to several million dollars.

20. (a) Individual PLAINTIFFS HENRY AND CAROLYN BLOCK are residents of Tucson, Arizona, and are the parents of three young children (ages six, four and five months). The total income for the family of five persons is approximately $200 a month (which is below the poverty guidelines) and is derived from the earnings of PLAINTIFF HENRY BLOCK who works at property maintenance, gardening and general repair services. They do not have the means to pay for medical and hospital services, and are ineligible for County Assistance for medical care. Arizona does not participate in the Federal Medicaid program.

(b) PLAINTIFFS CAROLYN AND HENRY BLOCK owe $88 to TUCSON MEDICAL CENTER as a result of emergency medical care rendered to their youngest child and to PLAINTIFF CAROLYN BLOCK. At the time the emergency care was rendered, TUCSON MEDICAL CENTER was aware of their indigency status. Nevertheless, TUCSON MEDICAL CENTER has referred the bill to a collection agency which is now threatening to sue PLAINTIFFS CAROLYN AND HENRY BLOCK.

(c) TUCSON MEDICAL CENTER is a private nonprofit hospital in Tucson, Arizona, which required preadmission deposits and full payment for all persons not covered by private insurance. If an indigent person applies for non-emergency admission, he is not admitted but is referred to the County Hospital. If an indigent person is admitted in an emergency, and is not eligible for County assistance and cannot be transferred to the County Hospital, he is billed in full, and his bills are turned over to a collection agency and he is sued.

(d) TUCSON MEDICAL CENTER enjoys tax exempt status as determined by DEFENDANTS under the Internal Revenue Code, and substantial donations to this hospital have been deducted by donors and further donations shall be deducted. On information and belief such donations are considerable.

21. (a) EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION represents poor persons in Floyd and Pike Counties, Kentucky, in confronting the health crisis in those Counties, including the problems of poor persons in obtaining hospital care and services. PRESTONBURG GENERAL HOSPITAL and PIKES-

VILLE METHODIST HOSPITAL are private, nonprofit hospitals in Floyd and Pike Counties respectfully, which refuse to admit and treat poor persons who are not covered by private health insurance and lack the means to pay pre-admission deposits. These hospitals refuse admission to poor persons covered by Medicaid if such persons cannot pay said pre-admission deposits.

(b) PLAINTIFF JOEY JAY BLEVINS, is a male child who resides with his parents and guardians MARY AND JAY BLEVINS in Honaker, Kentucky. In the fall of 1967, while the BLEVINS family was without income, JOEY JAY BLEVINS, who was then five years old, suffered a broken leg in a fall. MARY AND JAY BLEVINS, after experiencing difficulty in arranging transportation, took JOEY to the emergency room of the PRESTONBURG GENERAL HOSPITAL. Two doctors examined the leg and informed the PLAINTIFFS that it was broken. After waiting two hours JAY BLEVINS inquired whether his son was going to be treated and was informed that the boy could be treated at the Hospital only if the Hospital would be paid for such treatment immediately. Having no money, MARY AND JAY BLEVINS arranged for transportation of their son to Lexington, Kentucky, 120 miles distant, where his leg was treated at the UNIVERSITY HOSPITAL. JOEY JAY BLEVINS was without treatment for 24 hours. PRESTONBURG GENERAL HOSPITAL has continued to engaged in similar refusals to treat poor people since that time.

(c) PLAINTIFF ARTIE TACKETT is the mother of 14 children whose family's monthly income is $242.00 by reason of her husband's participation in the Mainstream Program operated by the Department of Labor. In January 1971, PLAINTIFF TACKETT was suffering from severe abdominal pain and sought to be examined and treated at the PRESTONBURG GENERAL HOS-

PITAL. PLAINTIFF TACKETT was denied treatment because she was unable to pay the required advance fee.

(d) PLAINTIFF TORA MAE COLLINS is a resident of Tram, Kentucky and the Mother of one child. She and her husband have no income but are recipients of medical assistance (Medicaid). In April 1971, PLAINTIFF COLLINS was eight months pregnant and suffering from severe pain. She sought to be examined and treated at the PRESTONBURG GENERAL HOSPITAL and to make arrangements for the delivery of her baby. PLAINTIFF COLLINS was informed by a physician at the PRESTONBURG GENERAL HOSPITAL that she could not be admitted for the delivery of her baby if she did not have $90.00 in addition to her medical card (Medicaid). PLAINTIFF COLLINS was not examined by the physician despite her pain.

(e) PLAINTIFF BALLARD CABLE is 57 years old and a disabled coal miner. He is the father of three children and his family's sole income is $161.00 a month from public assistance. In December 1970, PLAINTIFF CABLE was suffering from a severe skin disorder and after examination by his physician, PLAINTIFF CABLE attempted to be admitted to the PRESTONBURG GENERAL HOSPITAL. At the admissions desk, PLAINTIFF CABLE presented his medical card (Medicaid) but was informed that there were not beds available. Moments later two people, a nurse and a relative of PLAINTIFF CABLE, both of whom had just come from the inpatient section of the hospital, informed PLAINTIFF CABLE that there were "plenty of empty beds." By reason of this denial, PLAINTIFF CABLE was not hospitalized for several days and only then after traveling 120 miles.

(f) PLAINTIFF VIRGINIA STEPHENS is 30 years old, the Mother of four children and a resident of Harold,

Kentucky. Her husband is unemployed and her family is presently without income. PLAINTIFF STEPHENS is pregnant and has been treated by a physician affiliated with the PRESTONBURG GENERAL HOSPITAL. He informed PLAINTIFF STEPHENS that unless she was able to pay the present bill ($127) owing for his services, he would stop treating her and she would not be admitted to the PRESTONBURG GENERAL HOSPITAL for the delivery of her baby. Unable to pay the outstanding bill, PLAINTIFF STEPHENS sought treatment from a physician in Pikesville, Kentucky. In June 1971, PLAINTIFF STEPHENS was informed she would not be admitted to the PIKESVILLE METHODIST HOSPITAL for the delivery of her baby unless she had $130.00.

(g) On or about June 25, 1971, representatives of the EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION met with the Administrator of the PIKESVILLE METHODIST HOSPITAL to discuss hospital admission policy. He informed the representatives of EKWRO that the PIKESVILLE METHODIST HOSPITAL "treat(s) Floyd County people just like Pike County people—if they don't have money, they don't get in."

(h) PRESTONBURG GENERAL HOSPITAL and PIKESVILLE METHODIST HOSPITAL enjoy tax exempt status as determined by DEFENDANTS under the Internal Revenue Code, and substantial donations, including donations for construction of new facilities, have been and shall be deducted by donors. On information and belief such donations are considerable.

22. On information and belief, there are approximately 40 million persons in the United States who are not covered by private health insurance, the vast majority of whom have resources which place them below

the official poverty guidelines of the U.S. Department of Labor and Office of Economic Opportunity. The individual PLAINTIFFS, and persons who are members of the organizational PLAINTIFFS, are representative of these persons who lack the means to pay for and/or be admitted into private, nonprofit hospitals which enjoy tax exempt status and the benefits of other provisions of the Internal Revenue Code of 1954 as "charitable" organizations.

23. By granting federal tax benefits to private hospitals which exclude all persons unable to pay for services and/or persons whose bills are payable under the Medicaid program and/or admitting as emergencies and thereafter suing for collection of bills persons with incomes too low to pay for medical services, the DEFENDANTS have encouraged and are encouraging such hospitals to deny their services to individual PLAINTIFFS and the class to which they belong, and to members of the organization PLAINTIFFS and persons they represent.

24. As a result of the action of DEFENDANTS, individual PLAINTIFFS and the class to which they belong, and members of organization PLAINTIFFS and persons they represent, have suffered and will continue to suffer injury in their opportunity and ability to receive hospital services in nonprofit hospitals which receive the benefits of tax exempt status and the benefits of other provisions of the Internal Revenue Code of 1954 as "charitable" organizations, and will suffer irreparable harm and the threat of irreparable harm.

CAUSES OF ACTION

25. DEFENDANTS, in granting tax exempt status under Section 501(c)(3) to private hospitals which deny admission and services to all persons who cannot pay, have violated and continue to violate the Internal Reve-

mue Code of 1954, as such hospitals are not organized and operated for charitable purposes, or any other purpose conferring tax exempt status, within the meaning of the Internal Revenue Code of 1954.

26. DEFENDANTS, by promulgating a ruling entitling private hospitals which deny admission and services to all persons who cannot pay to tax exempt status under Section 501(c)(3), have engaged in arbitrary and capricious conduct in violation of the Internal Revenue Code.

27. DEFENDANTS, by promulgating a ruling entitling private hospitals which deny admission and services to all persons who cannot pay, without a public hearing and the opportunity for interested and/or affected persons to present their views, arguments and positions, have violated the rule-making procedures required by the Administrative Procedures Act (5 U.S.C. 553).

28. DEFENDANTS, by failing to collect taxes due and owing from private hospitals which deny admission and services to all persons who cannot pay and from donors to such hospitals which have deducted donations to such hospitals from their adjusted gross incomes, have violated and continue to violate the Internal Revenue Code of 1954.

29. DEFENDANTS, by granting federal tax benefits to private hospitals which discriminate against persons unable to pay for medical services and against persons covered by the Medicaid program, have denied to such persons due process of law within the meaning of the Fifth Amendment to the United States Constitution.

RELIEF REQUESTED

WHEREFORE, PLAINTIFFS pray that this Court enter judgment for them and the class they represent as follows:

30. The Court order preliminary relief suspending the grant of tax exempt status to private hospitals which deny admission and services to persons unable to pay until final adjudication of this issue.

31. The Court order that this action be maintained as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

32. The Court issue prohibitory and mandatory injunctions directed to DEFENDANTS, their agents, servants, employees, attorneys, and all persons in concert and participation with them:

(a) enjoining them from granting exemption from income taxes to private hospitals pursuant to 501(c)(3) of the Internal Revenue Code of 1954 without requiring said hospitals to serve persons unable to pay and persons covered by Medicaid, without requiring proof that such hospitals do not deny service and otherwise discriminate against persons unable to pay and persons covered by Medicaid, and without requiring proof that such hospitals do not excuse people too poor to pay for the payment of bills for services rendered; from allowing individual and corporate contributors to such hospitals to deduct the contributions from gross income of their income tax returns under 170(a) through (c) of the Internal Revenue Code of 1954; and from allowing such hospitals all other benefits and advantages under 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954;

(b) requiring them forthwith to institute proceedings leading to the rescission, withdrawal, and revocation of

approval of applications granting exemption from income taxes under 501(c)(3) of the Internal Revenue Code of 1954 from private hospitals which do not serve persons unable to pay and persons covered by Medicaid; allowing individual and corporate contributors to such hospitals to deduct the contributions from gross income on their income tax returns under 170(a) through (c) of the Internal Revenue Code of 1954, and allowing such hospitals all other benefits and advantages under 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954;

(c) requiring all private hospitals which desire to attain or retain "charitable" tax status and eligibility for the benefits of Sections 501(c)(3), 170(a) through (c) and 642(c), 2055, 2106(a)(2), and 2522 of the Internal Revenue Code of 1954, to file specific data, on forms devised by the DEFENDANTS or their agents, and approved by this Court, for said purpose, verifying that said hospitals do afford service to persons unable to pay, do not discriminate against persons covered by Medicaid, do not require a deposit as a condition for admission for all persons not covered by private health insurance, and do not attempt to collect payment for persons determined to be too poor to pay for services;

(d) ordering them to collect all taxes due and owing because of the illegal designation of "charitable" to hospitals which do not serve persons unable to pay and persons covered by the Medicaid program.

33. The Court declare that in order for hospitals to qualify for the status of "charitable" within the meaning of the Internal Revenue Code of 1954, that such hospitals must not discriminate against and deny service to persons unable to pay and to persons covered by the Medicaid program.

34. The Court declare that the Commissioner of Internal Revenue lacked the legal authority to grant tax exempt status to hospitals which do not serve persons unable to pay.

35. The Court declare that the Commissioner of Internal Revenue lacked the legal authority to promulgate Revenue Ruling 69-545 without following the rule-making procedures of the Administrative Procedure Act.

36. The Court grant PLAINTIFFS such further and additional relief as this Court deems equitable, just, and proper.

Respectfully submitted,

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DATED: July 12, 1971

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[Title Omitted]

MOTION TO DISMISS

[Filed Nov. 18, 1971]

Defendants, John B. Connally, Jr., Secretary of the Treasury of the United States, and Johnnie M. Walters, Commissioner of Internal Revenue, move this Court, pursuant to Rule 12 of the Federal Rules of Civil Procedure, for the entry of an order dismissing plaintiffs' complaint on the grounds that:

1. This Court has no authority to grant the relief requested because the provisions of 28 U.S.C., Section 2201 forbid the granting of a declaratory judgment with respect to Federal taxes.

2. Under the provisions of Section 7421(a) of the Internal Revenue Code of 1954 (26 U.S.C.) this Court has no jurisdiction to enjoin the assessment and collection of Federal taxes.

3. This Court has no jurisdiction over the subject matter of this action because:

(a) The matters complained of do not present a justiciable case or controversy within the meaning of Article III of the Constitution of the United States, and are not otherwise justiciable, and

(b) No one of the plaintiffs has standing to maintain this action.

4. This Court does not have jurisdiction over the persons of the defendants, inasmuch as the suit is, in fact,

one against the United States, and, as such, is barred by sovereign immunity.

5. The complaint fails to state a claim upon which relief can be granted.

/s/ John J. McCarthy
JOHN J. MCCARTHY
Chief
General Litigation Section

/s/ George F. Lynch
GEORGE F. LYNCH
Assistant Chief
General Litigation Section

/s/ Jack B. Teplitz
JACK B. TEPLITZ
Trial Attorney,
Tax Division
Department of Justice
Washington, D.C. 20530

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1370-71

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al., PLAINTIFFS

vs.

JOHN B. CONNALLY, JR., as Secretary of the Treasury of the United States, et al., DEFENDANTS

ORDER

[Filed May 10, 1972]

The defendants having moved for an order dismissing the complaint herein, on the grounds: that this Court has no authority to grant declaratory relief in the instant proceeding because 28 U.S.C. 2201 forbids the granting of said relief with respect to Federal taxes; that this Court has no jurisdiction to issue injunctive relief by virtue of the provisions of 26 U.S.C. 7421(a) forbiding the enjoining of the assessment and collection of taxes; that this Court has no jurisdiction over the subject matter because the matters complained of do not present a justiciable case or controversy and the plaintiffs have no standing to maintain this action; that the suit is barred by sovereign immunity; and that the complaint fails to state a claim upon which relief can be granted,

Now, after consideration of the motion, the opposition thereto, the pleadings, and argument of counsel, it is by the Court this 10th day of May, 1972

ORDERED, that the said motion be denied in all respects.

/s/ Barrington D. Parker
U.S. Federal Judge

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

[Title Omitted]

MOTION FOR SUMMARY JUDGMENT
AGAINST DEFENDANTS

[Filed April 10, 1973]

Plaintiffs move this Court to enter, pursuant to Rule 56 of the Federal Rules of Civil Procedure, a Summary Judgment in Plaintiffs' favor against the Defendants, declaring that granting tax exempt status to hospitals as "charitable" institutions, and permitting donors to deduct from their income tax contributions to such institutions, without requiring said hospitals to admit and provide free services to persons unable to pay, violates the Internal Revenue Code (26 U.S.C. 501(c)(3) and 170(a) through (c)), that the procedures under which such policy was promulgated violates the Administrative Procedures Act (5 U.S.C. 553 and 706(A)(2)) and the due process clause of the Fifth Amendment, that such practices are hereby restrained and enjoined, and that Defendants are charged to rescind said ruling and to collect all taxes due and owing because of such illegal actions.

This Motion is based upon the following:

(a) the pleadings;

(b) the Affidavits from Individual and Organizational Plaintiffs;

(c) STATEMENT OF ORGANIZATIONS AND INDIVIDUALS REPRESENTING INDIGENT AND MEDICALLY INDIGENT PERSONS CONCERNING THE DEFINITION OF "CHARITABLE" HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE

CODE, with attachments and Affidavit of Anthony Z. Roisman;

(d) Statement of Material Facts Not in Dispute;

(e) Memorandum of Points and Authorities in Support of Motion.

Plaintiffs also refer to Affidavits submitted in the case of *Cook et al* vs. *Ochsner Foundation Hospital et al*, Civ. Act. No. 70-1969, E.D. La., copies of which are attached hereto.

DATE: April 10, 1973

Respectfully submitted,

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INDEX OF EXHIBITS

Exhibit 1	Xerox pages of chapter 4, Report of the Staff to the Senate Committee on Finance, 91st Cong., 1st Session, Feb. 9, 1970.
Exhibit 2	Statement of organizations and individuals representing indigent and medically indigent persons with attachments to Commissioner of Internal Revenue, June 18, 1971.
Exhibit 3	Affidavit of Anthony Z. Roisman
Exhibit 4	Affidavit of Eula Hall, Chairman, Health Committee, Eastern Kentucky Welfare Rights Organization
Exhibit 5	Affidavit of Artie and Clarence Tackett
Exhibit 6	Affidavit of Tora Mae Collins
Exhibit 7	Affidavit of Lards Collins
Exhibit 8	Affidavit of Carolyn Block
Exhibit 9	Affidavit of Howard Linville, Treasurer, Association of Disabled Miners and Widows
Exhibit 10	Affidavit of Rosezella Cook
Exhibit 11	Affidavit of Monica Hunter
Exhibit 12	..... (reserved number of Affidavit of National Tenants Organization)
Exhibit 13	Affidavit of Rachel Miller, President, California Welfare Rights Organization
Exhibit 14	Affidavit of Marilyn G. Rose, to which are attached copies of Affidavits in the case of *Cook et al.* vs. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70-1969, E.D. La.
Exhibit 15	Letter of Rosemarie Shomstein, Senior Research Assistant of Health Insurance Institute

EXHIBIT 1

91st Congress
1st Session

COMMITTEE PRINT

MEDICARE AND MEDICAID

Problems, Issues, and Alternatives

REPORT OF THE STAFF

TO THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

[SEAL]

FEBRUARY 9, 1970

Printed for the use of the Committee on Finance

CHAPTER FOUR

TAX-EXEMPT STATUS OF COMMUNITY HOSPITALS AND OBLIGATION TO PROVIDE CHARITABLE CARE

The staff believes the committee's attention should again be called to the potential cost implications for medicare, medicaid, and other public programs of Internal Revenue Service Ruling 69-545, announced on October 8, 1969. That ruling overturns earlier IRS decisions that a hospital, in order to qualify for tax exemption under section 501(c)(3) of the Internal Revenue Code must provide charitable or below-cost care to the extent of its financial ability.

The tax reform bill passed by the House of Representatives (H.R. 13270) also contained a provision which removed the charitable or below-cost care requirement as a condition of tax exemption for hospitals. Ruling 69-545 was issued subsequent to House passage of the tax bill. On October 28, 1969, the Finance Committee deleted the provision contained in the House bill, indicating that it desired to consider the question in the context of medicare and medicaid. The committee action was approved by the Senate and accepted by the House.

Prior to consideration of the House bill in the Senate, the Committee on Finance instructed the staff to summarize the various provisions in the bill and to describe the major arguments for and against the amendments contained in the bill. Insofar as this hospital amendment was concerned, this "Summary of H.R. 13270, the Tax Reform Act of 1969 (as passed by the House of Representatives), August 18, 1969," stated as follows:

11. *Hospitals*

Present law.—Hospitals qualify for exempt status and may receive deductible charitable contributions as "charitable" organizations.

Problem.—It has been contended by some agents that hospitals (unlike educational organizations, churches, and others) must provide some significant amount of charitable services on a no cost or loss basis in order to be exempt as "charitable" organizations.

House solution.—The bill provides that hospitals are to have the same status as churches and educational institutions for purposes of tax exemption, charitable contributions, and a variety of other matters. The other requirements for exemption—no inurement of profits to private individuals, operation and organization exclusively for exempt purposes, no substantial legislative activities, and no political electioneering activities—continue to apply to hospitals.

Arguments For.—(1) These provisions are necessary to eliminate challenges to the tax-exempt status of hospitals on the ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates that are substantially below cost.

(2) By establishing hospitals as a separate exempt category and removing the indefinite test of to what extent a hospital must serve those who cannot pay, this bill removes the uncertainty surrounding the hospital's continued ability to draw necessary support from the public or from private foundations to accomplish its function.

(3) Hospitals perform a useful function of the sort that deserves treatment in section 501(c)(3) on the same basis as the other organizations specifically named in that provision.

(4) The present environment of governmental assistance to permit medical care to be made available to those otherwise unable to pay, appears to make obsolete the need for hospitals themselves to subsidize the providing of medical care to poor people. This is as true regarding hospitals as it is regarding schools and churches.

Arguments against.—(1) In order to be tax exempt, hospitals historically have been required to render service to the poor whether or not there was an ability to pay for the services rendered. These provisions would do away with that requirement and many marginal income families that are now ineligible for payment of hospital care under Medicaid, and who do not have sufficient resources to pay for hospital treatment might be denied care now available to them. This is especially true in States that do not pay for hospital care of people who are eligible for general assistance under the welfare programs of the State. The bill will pose particular hardships on poor families priced out of hospital care by continually rising health costs and this will put greater pressure on Congress to expand the Medicaid program at the very time Congress is seeking to contract and moderate it.

(2) To the extent hospitals contend Medicare and Medicaid does not pay their full costs they would also contend that they are providing *charitable* services for those patients. If the bill were not changed these hospitals could refuse Medicare and Medicaid patients with impunity or could limit their services to such patients unless the Government met the hospitals' unilateral cost demands. Without the balanc-

ing effect of the present Internal Revenue Service position, government might be faced with the choice of either complying with such payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals.

(3) There is no substantial evidence that contributors to hospitals will decrease or stop their donations because the Internal Revenue Service is questioning the tax-exempt status of a hospital (or hospitals) on the ground that sufficient charitable services are not being rendered to the poor.

(4) The extent of free and "below cost" hospital care has diminished greatly with the advent of public programs such as Medicare and Medicaid. The pressure to provide free care has lessened to the extent that these multi-billion dollar programs and private hospital insurance are now paying for many of those whose bills previously went unpaid.

(5) The bill discards the charitable basis—the "community service to all" concept—on which tax exemption of hospitals is founded.

(6) If there is a legitimate complaint that Internal Revenue rulings are too vague on this point, a clarifying amendment establishing statutory standards is the appropriate remedy rather than the blanket approach of the House provision.

(7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis.

The committee will recall the concern over the implications of the House-adopted provision expressed by the National Governors' Conference in the letter addressed to the chairman (reproduced below) and in subsequent

correspondence. Recently in the District of Columbia indigent patients were referred by some nonprofit community hospitals to the publicly operated D.C. General Hospital because of the inability of the District government to pay more than 80 percent of outpatient hospital costs for indigent patients. This situation appears to reinforce the anxiety expressed by the National Governors' Conference. The prior rulings of the Internal Revenue Service provided a measure of protection against any unreasonable refusal by a nonprofit hospital to provide charitable and below-cost care.

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., October 27, 1969.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR LONG: I understand that the Senate Finance Committee will soon be considering in Executive Session a section in the Tax Reform Act of 1969 that provides that private, non-profit hospitals can no longer be challenged to defend their tax exempt status in terms of the amount of charitable services they provide. This provision, as contained in the House passed bill, HR 13270, and in a recent Internal Revenue Service ruling, could result in hospitals refusing to serve Medicare and Medicaid patients or limiting their services to such patients unless the state meets the hospitals' demands for a certain level of payment.

I urge you, as Chairman of the Senate Finance Committee, to provide in the Tax Reform Act of 1969 for some means for states to control levels of payment to hospitals without endangering the avail-

ability of services for Medicare and Medicaid patients.

States have found it necessary to place some control on levels of payments to providers under the Medicaid program. Unless this control on the costs of Medicaid is maintained, states will be faced with an even greater financial burden under Medicaid, as will the Federal government.

Governors of states that have recent experience with freezing of levels of payment to hospitals and with challenges to the tax exempt status of hospitals will also be contacting you on this matter.

Sincerely,

CHARLES A. BYRLEY.

On the same day on which the Finance Committee deleted the House amendment, October 28, 1969, the American Hospital Association in its formal testimony on medicare before the Committee on Ways and Means included the following statement by Mr. Mark Berke, president-elect of the organization:

> "The institutional health care system differs from the rest of the private sector in its philosophy toward and treatment of patients who are unable and or unwilling to pay. Other members of the private sector maintain their right to not sell their product to someone who cannot afford it or is unwilling to pay for it.
>
> *Community hospitals, because of their public responsibility, do not take such action. The right to receive service regardless of the ability to pay is extended to the entire community,* and consequently the entire community has an obligation to share in these costs." [Emphasis supplied.]

Particular attention is called to the statement that "The right to receive service regardless of the ability to pay is extended to the entire community . . ." If the testimony of the American Hospital Association before the Committee on Ways and Means is a fair and accurate presentation of the hospitals' position, the staff is at a loss to understand why the hospitals sought the House amendment in the first instance.

Furthermore, the staff cannot reconcile that statement of dedication to the poor with the example of a tax-exempt hospital included in Revenue Ruling 69-545:

> "Hospital A is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. . . . The hospital operates a full-time emergency room and no one requiring emergency care is denied treatment. *The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization. . . . Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community which does serve indigent patients.*
>
> *The hospital usually ends each year with an excess of operating receipts over operating disbursements* from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research." (Emphasis supplied.)

In the Internal Revenue Service example of what it proposes to recognize as a tax-exempt hospital, "The right to receive service regardless of the ability to pay" is clearly *not* extended to the entire community.

The staff strongly recommends revocation of Revenue Ruling 69-545 in light of the recent legislative history

and continuation of the prior position of the Service until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients.

EXHIBIT 2

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June 18, 1971

Commissioner of Internal Revenue
Attention: CC:LR:T
Washington, D.C. 20224

Re: Hearing on Proposed Regulations

Dear Sir:

In accordance with the Notice of Hearing of proposed amendments to the regulations under section 170 (b) (1) (A) of the Internal Revenue Code of 1954, and my letter of June 8, 1971 requesting an opportunity to testify on behalf of the National Legal Program on Health Problems of the Poor and a number of its organizational and individual clients, I have enclosed five (5) copies of our Statement and supporting Documents.

As I mentioned in the letter of June 8, 1971, in view of the fact that a member of our Staff from California shall testify, we would like to be given a specific date and time for appearing. Would you please so inform us at this address, and also inform Mr. Anthony Z. Roisman

(Berlin, Roisman and Kessler, 1910 N. Street, N.W., Washington, D.C. 20036, 833-9070) who shall appear on our behalf.

Sincerely yours,

Marilyn G. Rose
Chief, Special Litigation

MGR/cm
Enclosures
cc: Anthony Roisman
bcc: Lawrence Norton
Jeffrey Schwartz
Peter Sitkin
Daniel Karnes
Peter Axelrod
Bruce Rogow

STATEMENT OF

ORGANIZATIONS AND INDIVIDUALS REPRESENTING INDIGENT AND MEDICALLY INDIGENT PERSONS CONCERNING THE DEFINITION OF "CHARITABLE" HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE CODE

This statement and these documents are submitted by and on behalf of the following organizations and individuals concerning the definition of "charitable" as it pertains to hospitals under Section 170 of the Internal Revenue Code, as amended by the Tax Reform Act of 1969:

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I. SUMMARY OF STATEMENT

Historically under the Internal Revenue Code hospitals have only been eligible as beneficiaries of tax-deductible contributions if they rendered "charitable" services, i.e. if their facilities were open to all persons in the community including persons unable to pay for services. In 1969 spokesmen for the American Hospital Association sought to have sections 170 and 501(c)(3) amended to provide that hospitals could be eligible for the benefits of said provisions without regard to qualifying as "charitable." The House Ways and Means Committee reported its bill with the amendments sought by the American Hospital Association. These amendments were not acceptable to the Senate Finance Committee, which stated that it desired to consider the issue in context of its study of Medicare and Medicaid. The amendments were deleted from the House bill in Conference and did not become a part of the Tax Reform Act of 1969. Congress then left the law in its "historic" state.

However, in the interim between the House Report and the Senate Report, the Internal Revenue Service issued an informal ruling under the tax exemption provisions of section 501, by which it "reinterpreted" the meaning of the work "charitable" and eliminated the requirement that hospitals must not close their doors to persons unable to pay in order to qualify for tax exempt status. Since that action private hospitals which heretofore gave some charity service have closed down those facilities or otherwise closed their doors to the poor. We believe that such closures, even if not actually caused by the Ruling, have at least encouraged them.

There is a health crisis in this country, and the poor are bearing the brunt of it. Public hospitals are underfinanced, understaffed, underequipped, and inadequate to care for all persons seeking their aid. Private hospitals,

which receive the benefits of the tax provisions for "charitable" organizations, are turning the poor away in a multiple of ways, including: erecting deposit requirements beyond the means of even the average person to pay (but waiving the deposits for those with health insurance), closing their clinics, transferring the poor and the "unacceptable" to the overcrowded public hospitals, refusing to participate in the Medicaid program.

We believe that these factors require the Internal Revenue Service to clarify the standards for hospitals to be eligible for the status of charitable donees of otherwise taxable dollars under section 170 of the Internal Revenue Code by re-establishing and enforcing the historic legal requirements that such hospitals must not close their doors to the poor and that no hospital which refuses to give services to the indigent and medically indigent of its community can be considered a "charitable" hospital. This action is necessitated because of the consequences of the ill-conceived and unwise ruling on tax exempt status of charitable hospitals. As detailed herein, we contend that affording "charitable" status to a hospital under § 170 which refuses to afford services to the poor is: (1) legally infirm and (2) is unwise and poorly considered policy from a health and social standpoint.

II. THE LEGAL REQUIREMENTS OF THE CHARITABLE STATUS OF HOSPITALS UNDER SECTION 170 OF THE INTERNAL REVENUE CODE

The Internal Revenue Service, just as any other agency of Government, has no power to amend the Statute under which it operates, whether by regulation or by interpretive action. The legislative history of the charitable deduction provision in the Internal Revenue Code, longstanding judicial interpretation of that provision as it

relates to hospitals, and, most especially, the expressed intention of the 91st Congress require that IRS require hospitals to provide services to persons unable to pay in order to be eligible for the tax deduction benefits of the Code, until and unless Congress by appropriate legislation authorizes a different policy.

Admonitions of the Supreme Court to the Internal Revenue Service support this claim that IRS must abide by this legislatively approved interpretation. Thus, in *Fribourg Navigation Co.* v. *C.I.R.*, 383 U.S. 272, 283, the Court stated,

> "Over the same extended period of years during which the foregoing administrative and judicial precedent was accumulating, Congress repeatedly re-enacted the depreciation provision without significant change. Thus beyond the generally understood scope of the depreciation provision itself, the Commissioner's longstanding and consistent administrative practice must be deemed to have received congressional approval."

In *United States* v. *Leslie Salt Co.*, 350 U.S. 383, 396-7, the Court said,

> "Against the Treasury's prior longstanding and consistent administrative interpretation its more recent *ad hoc* contention as to how the statute should be construed cannot stand. Moreover, the original interpretation has had both express and implied congressional acquiescence, through the 1918 amendment to the statute . . . which has ever since continued in effect, and through Congress having let the administrative interpretation remain undisturbed for so many years. [cite]"

(A) *The Legislative History of the Charitable Tax Deduction Provision Requires Hospitals to Serve Persons Unable to Pay.*

The origin of the provisions dealing with tax deduction and tax exemption under the Internal Revenue Code stems from section 32 of the Act of August 27, 1894, which exempted from taxation "corporations, companies or associations organized and conducted solely for charitable, religious, or educational purposes." Although the legislative history for inclusions is scant (the focus of congressional debate being the value of a tax on incomes vis-a-vis a tariff on imports), the inclusion of a specific exempt classification for hospitals apart from charities would not have been novel if the sponsors of the legislation so desired. In England it was reported that exemptions extended to "charities, universities, friendly, industrial, and provident societies, hospitals, etc. . . ." (Cong. Rec., Vol. 26, 53rd Cong., pp. 584, 586, Jan. 9, 1894). It could also be found in the laws of certain States. E.g., in New York hospitals were an "exempt" classification, provided that they rendered medical care to "poor persons in need of such treatment without charge" (a requirement which was subsequently removed *legislatively*). See *People* v. *Sexton*, 48 N.Y.S. 2d 201, 267 App. Div. 736 (Appellate Division, 1944).

The same provisions with respect to corporations and organizations for "religious, charitable, or educational purposes" were carried into the corporation excise law of 1909 (section 38, Act of August 5, 1909, 36 Stat. 11) and the income tax of 1913 (section II(G)(a), Act of October 3, 1913, 38 Stat. 114). With respect to the act of 1913 it should be noted that while a suggestion of Congressman Rogers to add "scientific" to the list of tax exempt purposes was accepted, his amendment with respect to adding "benevolent" was not accepted (Cong.

Rec., Vol. 50, pp. 1305-1306, 63rd Cong., 1st Sess.). In support of that latter inclusion he had stated,

> ". . . it has been held in Massachusetts that a corporation may be 'charitable' within the meaning of the Statute, without being 'benevolent,' and that it may be 'benevolent' without being 'charitable.' Therefore, in view of the undoubted fact, as I conceive it, that we ought to care not merely for charitable corporations, but also for benevolent corporations, it seems to me clear that this word should be added . . ."

Congress was obviously unwilling to accept such an inclusion.

In 1924 it rejected a more specific suggestion to take "charitable" out of its limiting "relief of the poor" context. Thus when Senator Willis of Ohio proposed to add to the predecessor provision of section 170 parenthetical language after "charitable" so as to define that term to include "preventive and constructive service for relief, rehabilitation, *health*, character building, and citizenship," the sentiment was expressed in the Senate that such terms were too elastic and that Congress had gone as far as it should go with the revenues of Government. (Cong. Rec., Vol. 65, pp. 8171-8173, 68th Cong., 1st Sess.). Senator Willis had predicated the need for his amendment to reverse a 1923 Ruling [1] of the-then Commissioner of IRS "that gifts to financial federations doing welfare work and social service other than *relief to the poor* would not be among the allowable deductions." The effect of this purposeful refusal to broaden the scope of "charitable" beyond this 1923 Ruling and to include broad

[1] In Revenue Ruling II-27-1128, I.T. 1800, Int. Rev. Bull. II-1-2 (1923), p. 152-153, IRS contrasted "charitable" used in the broad sense for trust purposes and "charitable" used in its popular and ordinary sense pertaining to "relief of the poor," and held that the latter was the intent of Congress for internal revenue purposes.

social welfare purposes (including health) was to place the Congressional stamp of approval on the concept that charitable for tax purposes was to remain focused on the relief of the poor.

The tax deduction provision of the Internal Revenue Code defining "charitable" has remained the same in the intervening years.

In 1969 the American Hospital Association (hereinafter AHA) attempted to obtain exempt status and tax deduction eligibility for hospitals under sections 501(c)(3) and 170, without regard to service to persons unable to pay. It sought to obtain such benefits by means of amendments to the Internal Revenue Code, and witnesses appeared in support of such propositions before the House Ways and Means Committee in February 1969 (Hearings before the Committee on Ways and Means, House of Representatives, Tax Reform 1969, 91st Cong., 1st Sess., Part 4 (February 26, 1969), 1425). The position of the AHA was directed toward an advancement of the proposition that the mere existence of a nonprofit hospital facility whose purpose is the advancement of health is charitable *per se* (Ibid, at 1428, 1433).

Congressman Gibbons of Florida questioned the AHA spokesmen about the effect of removing the tax exempt status requirement of service to the poor. Despite their protestations that voluntary hospitals carried "a public trust," he voiced skepticism about hospital beneficence if the coercive pressure to serve the poor was removed (Ibid at pp. 1440-1441).

No one testified on behalf of the poor, and no reference was made to the inadequacies of the present system to deal with their hospital needs. The House Bill, as reported in August 1969, contained provisions which added "hospitals" to the list of organizations to which 170 "charitable" contributions could be made (House Report

on Tax Reform Act of 1969, 91st Cong., 1st Sess., U.S. Code Congressional and Administrative News, p. 1688). The rationale in the House Report for the admendment to the Code was basically one proffered by the AHA, i.e. that the present enforcement of the law "has resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."

However, the House Amendment was struck from the provision in the Senate Bill, and the Conference version (and the ultimate Act as it became law in Dec. 1969) followed the Senate version. (Conference Report on Tax Reform Act of 1969, 91st Cong., 1st Sess., U.S. Code Cong., & Admin. News, p. 2404). There exists a quite detailed history for the Senate deletion of the House amendment in the Report of the Staff of the Senate Finance Committee, to the Committee, issued in February 1970. (*Medicare and Medicaid, Problems, Issues, and Alternatives*, Report of the Staff to the Committee on Finance, Senate, 91st Cong., 1st Sess., pp. 55-58). Included in that history is a letter to the Senate Finance Committee from the National Governors' Conference opposing the amendment:

> "I understand that the Senate Finance Committee will soon be considering in Executive Session a section in the Tax Reform Act of 1969 that provides that private, nonprofit hospitals can no longer be challenged to defend their tax exempt status in terms of the amount of charitable services they provide. This provision, as contained in the House passed bill, H.R. 13270, and in a recent Internal Revenue Service ruling, could result in hospitals refusing to serve Medicare and Medicaid patients or limiting their services to such patients unless the state meets the hospitals' demands for a certain level

> of payment. I urge you, as Chairman of the Senate Finance Committee, to provide in the Tax Reform Act of 1969 for some means for states to control levels of payment to hospitals without endangering the availability of services for Medicare and Medicaid patients.
>
> "States have found it necessary to place some control on levels of payments to providers under the Medicaid program. Unless this control on the costs of Medicaid is maintained, states will be faced with an even greater financial burden under Medicaid, as will the Federal Government."

The Staff had earlier prepared arguments in support of and against the amendments. The major thrust of its arguments for the amendments related to the "obsolete" nature of the requirement in view of Government funded health programs; the major thrust of its arguments against the amendment related to the impact on poor people ineligible for hospital coverage under the Medicaid program and on the costs to Government forced to increase the payment and coverage under Medicare and Medicaid or faced with the possibility of "seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals."

Apparently the pleas concerning the impact of Medicare and Medicaid had their effect, for the Senate deleted the provision from the bill "indicating that it desired to consider the question in the context of Medicare and Medicaid." As noted, the Tax Reform Act of 1969 was enacted without the House amendment permitting hospitals tax exempt and tax deductible status without requiring care to persons unable to pay.

Congress clearly did not intend that IRS should grant hospitals tax deductible status without regard to service to the poor, until and unless Congress decided the issue.

However, the uncertain state of affairs created by Revenue Ruling 69-545 on tax-exemption requires that IRS clarify the issue and "restore" the prior legal position, which most appropriately can be done by regulations under section 170.

(B) *Decisions of the Tax and Federal Courts Require that Hospitals Serve the Poor in Order to Be Eligible for Status as "Charitable" Institutions.*

Revenue Ruling 56-185 set forth the basic historic position of the Courts and IRS as to the requirements for hospitals to be eligible for charitable status under both 501(c)(3) and 170. (1956-1 Cum. Bul. 202). To the extent pertinent hereto, that Ruling specifically required that a qualifying hospital:

". . . must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."

In numerous cases through the years the Tax and Federal Courts have taken that position. See *C.I.R.* v. *Battle Creek Sanitarium*, 126 F.2d 405 (C.A. 5, 1942); *Intercity Hospital Ass'n* v. *Squire*, 56 F. Supp. 472 (W.D. Wash., 1944); *Davis Hospital Inc.* CCH Dec. 14,456 (M), 4 TCM 312, March 14, 1945; *Goldsby King Memorial Hospital*, CCH, Dec. 14,042 (M), 3 TCM 693, July 19, 1944; *Robert C. Olney*, CCH Dec. 23,265 (M), 17 TCM 982, Nov. 28, 1958; *John J. Cranley, Jr.*, CCH Dec. 24,609 (M), 20 TCM 20, Jan. 18, 1961; *Sonora Community Hospital*, 46 T.C. 519 (1966); *Lorain Avenue Clinic*, 31 T.C. 141 (1958). Cf. *Hassett* v. *Associated Hospital Service Corporation*, 125 F.2d 611 (C.A. L, 1942).

Thus in *Battle Creek* the Fifth Circuit stated,

"It is also usual for hospitals and sanitariums to charge those able to pay for services rendered, in order to pay for the expenses of the institution, while not denying treatment to others unable to pay anything. Such institutions are classed as charitable." (At 406).

The Tax Court followed this position in *Davis Hospital*, *supra*, and *Goldsby Memorial*, *supra*, during the same mid-1940's period. More recently, in 1966 in *Sonora Community Hospital*, *supra*, the Tax Court rejected the notion that hospital care *per se* is charitable, stating,

"The mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes. While the diagnosis and cure of diseases are indeed purposes that may furnish the foundation for characterizing an activity as 'charitable,' something more is required" (At 525-526).

Back in 1942 the First Circuit too had rejected the notion that the nonprofit dedication to health was *per se*

entitled to tax benefits as charitable (See *Hassett* v. *Associated Hospital Service Corporation*, 125 F.2d 611).

In the Ruling reversing the requirements for tax exempt hospitals, and permitting such exemption despite no care to the poor, IRS relies solely upon the authority of Scott, in his treatise on Trusts and in the Restatement of Trusts (of which he is the principal reporter) that:

> ". . . the promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit does not include all members of the community such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." (Revenue Ruling 69-545, 1969, Int. Rev. Bull. No. 44)

The misplaced reliance upon this authority shall be discussed *infra*, in context of the discussion on policy considerations. However, even assuming the policy considerations are the same for tax purposes as for trust purposes, the status of an organization to receive benefits under the Internal Revenue Code exist purely by that Statute. The legislative history, most particularly that in 1924 and in 1969, and the historic judicial interpretation of the meaning of "charitable" as it pertains to hospitals under the Internal Revenue Code, require IRS not to permit taxpayers to take as charitable deductions contributions to hospitals which "refuse to accept patients in need of hospital care who cannot pay for such services."

III. The Policy Considerations for Requiring that Private Hospitals Furnish Services to Persons Unable to Pay

The Staff Report to the Senate Finance Committee, in the subpart dealing with the obligation of community hospitals to provide charitable service under the Internal Revenue Code, concludes with the recommendation that the Revenue Ruling dealing with tax exempt status of hospitals which do not serve the poor be revoked "in light of the recent legislative history and continuation of the prior position . . . [s]uch action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients." This recommendation should be followed also in regard to the eligibility of hospitals to receive tax-deductible contributions. Aside from the legal requirements, the policy considerations underlying the grant of tax benefits to hospitals militate a requirement that the indirect subsidization of hospitals through the tax deduction provisions of the Internal Revenue Code[2] be only given to such hospitals as are open to all persons in the community, including persons unable to pay.

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[2] Cf. *Green* v. *Kennedy*, 309 F. Supp. 1127 (1970) that tax benefits under the Code operate not too unlike a grant-in-aid, and that contributions to institutions eligible for status under the tax benefits provisions of the Code encourage contributions. Such indirect subsidization can be considerable. For example, in fiscal year 1969, some $22.5 billion was spent for hospital care in the United States, and in addition $2.5 billion was spent for construction and modernization of health care facilities. Approximately 51% of the $25 billion total came from the private sector, with philanthropy providing $2.3 billion of that 51%. Of particular significance is the fact that of the $2.3 billion from charity, 1.5 billion was for construction or modernization of facilities (or 60% of the $2.5 billion spent for construction). Hearings Before the Subcommittee on Medicare-Medicaid, Committee on Finance, 91st Cong., 2nd Sess., p. 422.

There are different rationale for granting tax benefits through exemption of income and deductibility of contributions to the donees of charities than for rendering property inalienable indefinitely according to the will of the deceased ancestor, under the law of charitable trusts. As stated above, reliance upon the authority of Scott is misplaced, even assuming it is accurate.[a] Rather than evaluating the competing claims of private persons over the use of property, tax benefits arise from legislative balancing of two competing public interests: one being that everyone pays his share of the costs and expenses of government (e.g. *Cleveland Osteopathic Hospital* v. *Zengerle*, 91 N.E. 2d 261, 263, Ohio, 1950; *Presbyterian Homes* v. *Division of Tax Appeals*, 261 A2d 143, N.J., 1970); the other being that "Government is compensated for the loss of revenue by its relief from financial burdens which otherwise have to be met by appropriations from public funds. . ." (Report 1860, Ways and Means Committee, 75th Cong., 3rd Sess., pp. 19-20, Jan. 1939). This "lessening the burdens of government" thesis is reflected in the current Treasury Regulations defining "charitable" for tax exempt purposes (Treasury Regulation 1.501(c)(3)-1(1)(d)(2)).

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[a] Even for the law of trusts, however, the law is not settled that a hospital, *per se*, is "charitable" without regard to free services to the poor. As stated in *Trust Co. of Georgia* v. *Williams*, 192 S.E. 2d 913, 914 (Supr. Cr., Ga., 1937). "A hospital, however, is not any more than a drugstore, a charitable institution *per se*; and, in order for a devise or other gift establishing a hospital to come within the classification of a charitable institution, the terms of the gift must themselves require that it be operated in whole or at least in substantial part for the gratuitous relief of its inmates."

It is not altogether clear how Scott came to his conclusion; many of the cases he cites in his long footnote actually spell out the requirement that the poor as well as the rich be treated in charitable hospitals. E.g., *Hart* v. *Taylor*, 301 Ill. 344, 133 N.E. 857, 858 (1922); *O'Brian* v. *Physicians' Hospital Ass'n*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). They rather support the proposition that health is a purpose which may be charitable, provided that actual charity is bestowed. This is fully in keeping with the pre-1969 posi-

However, whether an institution should qualify for tax benefits as lessening the burdens of government requires an evaluation of its operations in the realities of

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tion of the IRS. As stated in *Sonora Community Hospital*, 46 TC 519, 525-6 (1966), "The mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes. While the diagnosis and cure of diseases are indeed purposes that may furnish the foundation for characterizing an activity as 'charitable' something more is required. See Rev. Ruling 56-185, 1956-1 C.B. 202."

The concept of charitable trusts emerges from the Statutes of Elizabeth I, and the relief of "aged impotent and poor people" set forth therein. This provision was part of the Elizabethean poor laws, and implicit throughout was the concept of assistance to the poor. As set forth in TenBroek, *California's Dual System of Family Law; Its Origin, Development, and Present Status*, 16 Stanford L. Rev. 257, 267 (1964),

> "Under the Tudors charitable foundations and the law of charitable trusts were developed in connection with the poor law. As the state assumed public responsibility for the poor, it built upon private charity and sought to encourage it. At best, such charity was an alternative to public expenditure; at least, it served as a method of reducing the cost. As the poor law system evolved, the Tudors sought to assure that charitable foundations devoted their resources without diversion or misapplication, that private and public charitable works were interrelated administratively, and the establishment of private charitable foundations occurred, especially in the area covered by the public responsibility. While we cannot ignore pressures arising from the political changes of the times and the developing *parens patriae* and police functions of the state, it is probably not too much to say that the modern law of charitable trusts evolved as an integral part of the poor law system and did so primarily because of the assumption of public responsibility by that system, with the resulting necessity of finding means of keeping down public expenditures."

The Statute was a product of the realization that laws against vagrancy and begging would not work if men were hungry, and the enlightenment when "the eminent statesmen of Elizabeth's reign courageously determined to act upon the principle that the relief of destitution must be undertaken as a public duty, and be provided for at the public charge, in order to ensure the due ascendancy of the law; and this principle was finally established by the passing of the 43rd Elizabeth." Nichols, *History of the English Poor Law*, 194 (1854).

its broad social context. For example, the accumulation of income for *future* charitable uses may not be sufficient for qualification. As stated by the Third Circuit in holding that the unreasonable accumulation of income deprived a charitable foundation of its tax exempt status:

> "It has no natural right to tax exemption, but rather a Congressional balm granted because losses in tax revenues were deemed compensated for by the value of charitable work. Absent a sufficient amount of charitable work commensurate with the total amount of Erie's available funds, exempt status must cease, or in fact, never come into existence." *Erie Endowment* v. *United States*, 316 F.2d 151, 153 (1963).

When one considers whether nonprofit hospitals which do not serve persons unable to pay for services should be nevertheless the beneficiaries of the Government's tax benefits policies, one must consider the over-all health delivery system in the United States, the crisis in that system, and the Government's policies and programs for dealing with that situation. In such a context the nonprofit, fee-charging hospital which does not serve the poor is not entitled to Government beneficence.

(A) *The Health Crisis in the United States and the Dual Hospital System Should be the Focus for Tax Policy in the Health Area.*

Accompanying this Statement is a collection of Documents, the common theme of which is the health crisis of the poor. Some of the Documents are Complaints filed in various Courts throughout the country and/or preliminary Decisions in some of the cases. Others are newspaper or magazine articles. They are illustrative of the fact that there is a health crisis in this country, and that the poor have been "squeezed" out of the system at the cost of their health and their lives.

The problems set forth in these Documents are manifold. In the first place they demonstrate that the poor are channeled into public hospitals in numbers beyond the capacity of the public hospitals with their limited budgets (determined by State or local governments) to cope, and that as a result serious shortages of staff, equipment, and facilities have precipitated charges of quality of care violations of statutory, regulatory, and constitutional obligations. (See, e.g., *Fisher* Complaint in Los Angeles (Document No. IIA), *Greater Washington Area Council of Senior Citizens* Complaint in the District of Columbia (Document No. IVA); Cf. *Boone* v. *Tate* Decision in Philadelphia (Document No. XIIA), and *Cook* v. *Ochsner* Complaint and newspaper clippings on Charity Hospital financial crisis in New Orleans (Documents Nos. VIIIA, VIIID).

In many of these places the private hospitals refuse to treat the poor (See *Cook* v. *Ochsner* Complaint in New Orleans; *Organized Migrant Workers* Complaint in Florida; *Perry* Complaint in the District of Columbia—Documents Nos. VIIIA, IVA, VA). Indeed, these fee-charging hospitals often discriminate against even the poor for whom the Government pays (See letters concerning minimal participation of New Orleans area fee-charging hospitals in Medicaid program, Document No. VIIB).

Throughout the country public hospitals have been faced with threatened or actual loss of accreditation (See clippings concerning the crises at public hospitals in the District of Columbia, Boston, St. Louis, Chicago—Documents Nos. IVB, VIA, IXA, XA), because of the quality of care problems. In other cities actual services and facilities have been curtailed (See *Boone* v. *Tate* Decision, clippings on New Jersey situation, *Cook* v. *Ochsner* Complaint and clippings on Charity Hospital crisis—Documents Nos. XIIA, XIA, VIIIA, XIIID).

In the private hospital system onerous deposit requirements are set as a barrier to the poor (See *Cook* v. *Ochsner* Complaint Document No. XIIIA), and the private hospitals have the notorious reputation for increasing the problems of the public hospitals by the practice of "dumping" their unwanted or poor patients upon the public hospitals. (See clippings reporting this practice in the District of Columbia and in Los Angeles, Documents Nos. IIB, IIIB). This practice has been recognized by persons within the inner sanctums of the hospital field. Thus, in the July 1970 issue of Hospitals, which is the official publication of the American Hospital Association, its feature editor states:

> "Whereas the 'mainstream' of health care during the 1950s and early 1960s was progressive and represented by research-oriented medical centers, public hospitals became the 'dumping grounds' for the medically indigent and had come to be identified with a dual standard of health care delivery. The passage of Medicare and Medicaid legislation in the mid-1960s was expected to unify the dual system. Unfortunately the private sector has not absorbed its proportionate share of the sick poor." (At 54)

It is a practice which violates the standards of the Joint Commission on Hospital Accreditation, which forbids transferring a patient without the permission of the recipient hospital, but nonetheless the practice persists.

In the April 1971 issue of Modern Hospital, it is reported that voluntary (i.e., private, nonprofit) hospitals have been limiting or eliminating the charity services in recent months (At pp. 40-41). In New Orleans, two of the private hospitals claim that they had free or below cost clinics which they closed in early 1970 (Answers to Interrogatories, *Cook* v. *Ochsner*, Civ. Act. No. 70-1969, E.D. La., 1970). Thus, while the public hospitals are

curtailing services because of budgetary limitations, so too are the private hospitals. At the same time States are claiming fiscal crisis in the Medicaid programs, most especially our wealthiest States of New York and California (See, *C.M.A.* v. *Brian*, Civ. Nos. 208390-209168, Superior Ct., Sacramento County, 1971; *Bass* v. *Rockefeller*, 71 Civ. 2088, SDNY, 1971). These documents describe a dual health system, the inadequate public one for the poor, the private one which is the beneficiary of all the major breakthroughs of modern medical science for the paying patients. This dual system has been characterized as "indefensible as a concept and unacceptable as a practice" (See, e.g., report of testimony before the Illinois State Senate investigating the plight of Cook County Hospital, Hospitals, May 1, 1970, p. 107). It is the practice which Medicare and Medicaid was suppose to eliminate. Indeed, specifically written into those Statutes is the "free choice" of providers requirement (See 42 U.S.C. 1395a, 1396a(a)(23)). During the hearings on Medicare and Medicaid in 1965, the California Medical Association expressed the sentiment that

> "it is important that the patient stay in the mainstream of medical care in his community. He should be subject to no discrimination or segregation from other citizens who are able to provide for their own care. He should be able to use the same facilities . . ." See Hearings before the Committee on Finance, U.S. Senate, 89th Cong., 1st Sess. on H.R. 6675, p. 656.

This dual health system has had a detrimental effect upon the health of the poor, and although a majority of the poor are not black, it has had a statistically measureable greater impact on the poor blacks. Although we have included only excerpts from the Devise Study (Document No. VIB), we commend the entire booklet for its documentation of the relationship between poverty and

race and poor health status. As noted in the Devise booklet, chapter 1, one of the most sensitive indices of health conditions in the community is its infant mortality rate, expressed as death of children under one year of age per 1,000 live births. In Chicago the non-white poverty community was measured as having an infant mortality rate of 45.5 per 1,000 live births compared to the white non-poverty community with 22.2 per 1,000 live births (See Devise, *Slum Medicine: Chicago's Apartheid Health System*, Jan. 1, 1969, U. of Chicago). Similarly, in the United States as a whole in 1967, infant mortality for whites was 19.7 per 1,000 live births and for nonwhites 35.9 (Statistical Abstract of the United States, 1969). In 1968, with an overall figure of 21.7 deaths per 1,000 live births, the United States ranked thirteenth among selected industrialized countries in infant mortality, following behind: Norway, Sweden, the Netherlands, Finland, Japan, Denmark, Switzerland, Australia, United Kingdom, New Zealand, East Germany, and France, (Population and Vital Statistics Report, Series A, Volume XXII, No. 1, January 1, 1970, United Nations).

This is the context in which tax benefits in the health area must be considered. It is the context to which the Senate Finance Committee deferred consideration of the issue, when it deleted the amendments giving hospitals as a class 170 and 501(c)(3) status apart from "charitable" in October 1969, a deletion which was accepted by the House in Conference.

(B) *Granting Hospitals Which Deny Admission to the Poor the Status of "charities" for Purposes of Section 170 of the Internal Revenue Code Defeats Both Tax and Health Policies.*

As stated above the decision to grant tax benefits to charities is the result of a legislative finding that the

benefits conferred (through a lessening of the burdens on the expenditures of government which would otherwise occur) outweighs the policy that everyone pays his share of the costs of government. The brief summary of the health crisis in the United States set forth above and in the attached documents demonstrates that when private hospitals take only patients who pay for the services rendered to them, and cast the entire burden of the poor upon the public hospitals, the burden on government increases. As cogently stated by the Illinois Court in denying tax exempt status to an old people's home which reserved the right to discharge a resident who became sick, unmanageable, or depleted his assets, and then to cast him upon the State for care,

> ". . . the State would be bereft of any asset or estate from which it might seek reimbursement for its outlay after the person's demise. We can only infer that plaintiff's use of its property in this respect could tend to increase, rather than lessen, the State's burden." *Methodist Old People's Home* v. *Korzen*, 233 N.E. 2d 537, 543, 39 Ill. 2d 149 (1968).

So too has the Louisiana Court, noting that the institution did not admit charity patients and scheduled charges even for welfare patients, stated,

> "there is no basis for the contention that plaintiff's operation in any degree whatsoever served to relieve the State or its governmental subdivision of the burden of caring for the sick and the indigent." *Ruston Hospital* v. *Riser*, 191 So 2d 664 (1966).

Likewise the New Jersey Courts have recognized that the failure to care for the aged poor by private homes casts a financial burden on the State. See *Presbyterian Homes* v. *Division of Tax Appeals*, 261 A2d 143, 55 NJ 275 (1970); *Catholic Charities* v. *City of Pleasantville*, 263 A2d 803, 109 N.J. Super, 475 (1970).

Further, Government health policy is directed toward the elimination of the dual system of health care. It was the objective of the Medicare and Medicaid systems. To the extent that the poor are still funnelled into the public hospitals, it is a reflection upon the private hospital system (See letters concerning non-participation of private hospitals in Medicaid in New Orleans, Document No. VIIIB) which has "chosen" not to participate. But should private hospitals which refuse to participate in extending health services to the entire community which must include the poor, and which cast the burden of the poor entirely upon the public sector, be granted subsidization of public revenues through tax benefits? That is the basic policy question. We believe that it belongs most appropriately with Congress. However, in view of the removal of the sanction of loss of tax exempt status, which has encouraged hospitals to close down charity services, we suggest that the Regulations under section 170 be amended to restore the prior, long-standing, and legally approved policy that only those nonprofit hospitals which do not turn the poor away may be the beneficiaries of tax-deductible contributions.

INDEX OF DOCUMENTS IN SUPPORT OF STATEMENT

[Documents Omitted]

Document No.:

I. Arizona

A. Affidavit of Carolyn Block

II. California—Quality of Care to Poor; an Issue in Public Hospitals in Los Angeles County.

A. *Dr. Charles Fisher, et al.* v. *County of Los Angeles, et al.*, Civil Action No. 96821 in the Superior Court of the State of California for the County of Los Angeles.

B. Newspaper clippings concerning the *Fisher* lawsuit.

III. Colorado—Poor Charge that Public Hospital Refuses to Serve Them Without Cost.

A. *Rafaelo Euresti, et al.* v. *Richard Stenner, et al.*, Civil Action No. C-2462 in the United States District Court for the District of Colorado.

IV. District of Columbia

A. *Greater Washington, D.C. Area Council of Senior Citizens, et al.* v. *District of Columbia General Hospital, et al.*, Civil Action No. 275-71 in the United States District Court for the District of Columbia.—Quality of Care Problem in D.C.

B. Newspaper clippings of problems at D.C. General.

C. *Elizabeth Perry, et al.* v. *The Greater Southeast Community Hospital Foundation, Inc., et al.*, Civil Action No. ——— in the United States District Court for the District of Columbia.—Poor Charge That Private Hospital Refuses to Treat Persons Unable to Pay.

INDEX OF DOCUMENTS (Continued)

V. Florida—Poor Charge Private Hospital Refuses to Treat Persons Unable to Pay.

A. *Organized Migrants in Community Action, Inc., et al.* v. *James Archer Smith Hospital, et al.,* Civil Action No. 70-1794-Civ. JLK in the United States District Court Southern District of Florida.

1. Complaint
2. Decision on Standing and Class

VI. Illinois—Quality of Care for the Poor an Issue in Chicago

A. Newspaper clippings concerning crisis at Cook County Hospital.

B. Excerpts from *Slum Medicine: Chicago's Apartheid Health System,* De Vise.

VII. Kentucky

A. Newspaper clippings on charges by poor that private hospital refuses to treat persons unable to pay—emergency results in death.

VIII. Louisiana—Poor Charge Private Hospitals Refuse to Treat Persons Unable to Pay and Persons on Medicaid, and Inequality of Care and Lack of Available Services Exist at Public Hospital.

A. *Rosezella Cook, et al.* v. *Ochsner Foundation Hospital, et al.,* Civil Action No. 70-1969 in the United States District Court, Eastern District of Louisiana, New Orleans Division. Complaint.

B. Letters concerning failure of private hospitals to Participate in Medicaid.

C. Court's Memorandum of Reasons in *Cook,* 319 F. Supp. 603, on Standing of the Poor.

INDEX OF DOCUMENTS (Continued)

D. Newspaper clippings concerning crisis at Charity Hospital.

IX. Massachusetts—Quality of Care—An Issue at Public Hospital in Boston.

A. Newspaper clippings concerning Boston City Hospital.

X. Missouri—Quality of Care, an Issue at St. Louis General Hospital.

A. Newspaper clippings.

XI. New Jersey

A. Clippings concerning the closure at public hospital of services to the poor.

XII. Pennsylvania—Lack of Money Results in Closing Services to the Poor at Public Hospital—Quality of Care Issue.

A. *George and Patricia Boone, et al.* v. *James H. J. Tate,* Civil Action No. 713 in the Court of Common Pleas of Philadelphia County Trial Division—Civil Section. Final Decree.

XIII. Miscellaneous Articles Regarding Health Crisis, Medicaid Cut-backs as States Face Financial Crises, etc.

EXHIBIT 3

AFFIDAVIT

District of Columbia, ss:

I, Anthony Z. Roisman, being duly sworn, deposes and state as follows:

1. I am counsel for plaintiffs in the action styled *E.K.W.R.O. et al.*, vs. *Schultz et al.*, Civ. Act. No. 1378-71. For several months prior to the commencement of the action on July 12, 1971, I consulted with legal service attorneys whose clients were poor people denied access into non-profit hospitals across the country because of their inability to pay for hospital services. These attorneys were particularly concerned with a recently issued ruling of the Internal Revenue Service (Rev. Rul. 69-545) that reversed the prior ruling (Rev. Rul, 56-185) that required non-profit hospitals not to deny service to the poor in order to retain "charitable" tax exempt status under section 501(c)(3) of the Internal Revenue Code.

2. On May 22, 1971 there appeared in the Federal Register a Notice of Hearing on Proposed Regulations concerning the "charitable" contributions provisions of the Internal Revenue Code (36 Fed. Reg. No. 100). Viewing this proceeding as an opportunity to present to the internal Revenue Service and the Department of the Treasury its views of the poor people with respect to the issue of "charitable" service of hospitals, in particular to contend that revenue ruling 69-545 was based on a lack of understanding of health crises poor people faced, and desiring a more favorable ruling in the "contributions" area, we filed a Statement (copy of which is attached to the Motion for Summary Judgment as Exhibit 2) on behalf of the National Legal Program on

Health Problems of the Poor and a number of its organizational and individual clients.

3. The hearing was conducted on June 28, 1971, and I appeared for the organizations, individuals, and programs identified on Exhibit 2. The chairman of the three member panel informed me that as I was present I could testify, but to be brief, as the matters which were the subject of my testimony were irrelevant to the purposes of the hearing, and that I was addressing myself to the wrong forum. I spoke approximately for ten minutes. The panel was not responsive to the issues I raised.

4. I reported to Marilyn Rose and Laurens Silver of the National Legal Program on Health Problems of the Poor what occurred at the meeting. Subsequently I was told by Ms. Rose and Mr. Silver that they had discussed the matter with the various local legal service attorneys and their clients, and the decision was made that a lawsuit challenging the action of Defendants was the only alternative open.

/s/ Anthony Z. Roisman
ANTHONY Z. ROISMAN

Sworn to before me this 6th day of April, 1973.

/s/ Phyllis L. Quander
Notary Public
My commission expires January 31, 1978.

(Official Seal)

EXHIBIT 4

AFFIDAVIT

State of Kentucky

County of Floyd

I, Eula Hall, being duly sworn, depose and state as follows:

1. The Eastern Kentucky Welfare Rights Organization, Inc., hereinafter E.K.W.R.O., was formed in September 1967 when a group of residents of Floyd County, Kentucky, distressed at their poverty, decided that poor people had a right to the decision-making process in the United States, particularly with regard to their health, education, and welfare.

2. I have been a member of E.K.W.R.O. from its founding, and am presently the Chairman of the Health Committee. The Health Committee was founded two years ago when problems developed with the O.E.O. funded comprehensive health program. The comprehensive health program had no doctors, no drugs, and served merely as an outpost or way station to funnel people to local medical facilities where patients were herded into and waited for hours in crowded clinics to be seen.

3. E.K.W.R.O. has grown to a membership of approximately 500 people, principally from Floyd County, but also from Pike, Knott, and Manifee Counties, Kentucky. The members must be low income, using the O.E.O. guidelines as the criteria for low income. Most of the men have been miners, who have either been injured or have contracted black lung disease. Many of our members actually have no income except food stamps, having been denied welfare and black lung benefits.

4. One of the principal projects of E.K.W.R.O. has been a proposal for the Mud Creek Health Program.

Mud Creek is the home for about ⅓ the population of Floyd County, some 10,000 people. Most of the men of Mud Creek are or have been employed as coal miners. The older men are usually disabled and suffer from chronic lung disease and related health problems such as enlarged heart. Because many of the strongest and healthiest people have left the area to go to industrial centers for work, those left behind in the mountains are often those who are most in need of health care: the aged, the injured, mothers and their children, and those men who face the day-to-day hazards of working in the coal mines. Most poor people who have grown up on Mud Creek also suffer from health problems related to poor housing and sanitation, and the lack of money to buy the necessary foods and medicines.

5. Health resources in Mud Creek are scarce, and transportation over Mountain roads is virtually nonexistent. Thus people go to seek health care when they feel it is an emergency, only to wait in crowded hospital clinics and emergency rooms all day long and into the night. Added to that is the fact that if people do not have money, they do not get treated.

6. As the Chairman of the Health Committee I have taken poor people to hospitals in the area and have waited with them for hours to be seen, only to be turned away because they had no money.

7. I have read the affidavits given by Artie and Clarence Tackett, Tora Mae Collins, and Lard Collins, and personally know that their circumstances in seeking health care unsuccessfully from hospitals in the area from which E.K.W.R.O. draws its members are typical.

8. In June 1971 I and other representatives of E.K.W.R.O. met with the Administrator of the Pikesville Methodist Hospital to discuss hospital admission policy. He informed us that the Pikesville Methodist

Hospital treats Floyd County people just like they treat Pike County people—if they don't have the money, they don't get in.

/s/ Eula Hall

Subscribed and sworn to before me this 31st day of January, 1973

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 5

AFFIDAVIT

State of Kentucky

County of Floyd

I, Artie Tackett, and I Clarence Tackett, being duly sworn, depose and state as follows:

1. We have fourteen children, seven of whom are still minors and live at home.

2. Clarence Tackett worked in the mines for twenty-one years, developed problems with breathing, and became unable to work any longer in the mines. He has not been determined eligible for social security benefits under the Black Lung Benefits Act, and the family has been subsisting only on food stamps. In 1971 he participated in the Mainstream Program, but there were no jobs.

3. In January 1971 Clarence Tackett took Artie Tackett to the hospital at Prestonburg (Highland General Hospital). She had had two previous heart attacks and he thought she might be having another heart attack. The nurse on duty asked for $50. When Clarence Tackett said that he did not have the $50, the nurse tore up the admission's application. He told the nurse that his wife had had two previous heart attacks, but the nurse refused to call a doctor. Clarence Tackett had to take Artie Tackett home without any treatment.

4. This is the typical action of all the hospitals in the area. In 1968 when Artie Tackett had a heart attack Clarence Tackett had to give the Beaver Valley Hospital his car (worth about $500) because he did not have even $50 for admission. About four years ago the Prestonburg Hospital would not admit their daughter Patty.

then 9, who was suffocating from worms, because they did not have the $50.

5. Clarence Tackett himself has black out spells, has shown positive on the tuberculosis skin test, and probably has cirrhosis, in addition to his probable black lung disease.

/s/ Clarence Tackett
Artie Tackett

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 11, 1977

EXHIBIT 6

AFFIDAVIT

State of Kentucky

County of Floyd

I, Tora Mae Collins, being duly sworn, depose and state as follows:

1. In June 1971 I went to the Prestonburg Hospital (Highland General). I was pregnant and had severe labor pains. I am a beneficiary of Medicaid and had a Medicaid card. However, the people on duty at the Prestonburg Hospital told me that my Medicaid card was not enough, that I needed $90 in addition. Two to three weeks earlier I had also been told by the people at the Prestonburg Hospital that my Medicaid card was not enough, that I needed $90. On both occasions they would not treat me, nor would anyone examine me although I was in severe pain.

2. My husband and I had absolutely no income and no resources, and had no way to pay for any medical care except for the Medicaid card. Unlike the Prestonburg Hospital the Pikesville said that the Medicaid card would pay for my care and I went there when I did deliver. I went to the Prestonburg Hospital earlier because it was a great deal closer and I did not think that I could make it to Pikesville. We do not have any transportation.

/s/ Tora Mae Collins

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 7

AFFID. VIT

State of Kentucky
County of Floyd

I, Lards Collins, being duly sworn, depose and state as follows:

1. In August 1972 Dr. Hodge sent me to Pikesville Methodist Hospital. He said that I had gallstones and needed an operation or I might bleed to death. He gave me a paper which I took to the hospital and gave to one of the nurses who sent me to the main office. At the main office I told them that I had only a $80 a month income, and nothing left after I paid rent and the gas bill and I had no health insurance.

2. I was told by the woman in the main office that they would not take me. I asked what would happen if I died. They said that Dr. Hodge was not running the place.

3. I worked for the railroad and was a miner for twenty years. But I am now disabled and receive the $80 a month as social security disability benefits. I have an application in for black lung benefits, which was rejected, but I have refiled and have heard nothing. I have no other income.

4. Dr. Hodge told me that my heart is weak and cannot stand the problems from my gallstones.

/s/ Lards Collins

Subscribed and sworn to before me this 31st day of January, 1973.

/s/ [Illegible]
Notary Public

My Commission Expires: January 4, 1977

EXHIBIT 8

STATE OF ARIZONA)
) ss.
COUNTY OF PIMA)

I, CAROLYN BLOCK, being first duly sworn, depose and say:

That my husband, HENRY BLOCK, and I live at 729 E. Mabel Street, Tucson, Arizona. We have three children, their ages are six years, 4 years and four months. The burden of expenses in keeping our children properly clothed and fed is large. In addition we must pay $90.00 per month for rent.

My husband, Henry Block, earns approximately $200.00 per month by working at property maintenance, gardening and general repair.

Our low-income makes it impossible for us to pay for hospital care. We are in an especially bad condition with respect to medical care because Arizona has no Medicaid Program to help us out.

At the present time we owe $88.00 in medical bills to Tucson Medical Center. The bills were incurred as a result of emergency medical care for our youngest child and emergency medical care for me. At the time of our medical treatment at Tucson Medical Center, the hospital was aware of our indigency status. Yet they have now turned the full bill over to a collection agency and we are being threatened with a suit.

Tucson Medical Center refuses to let poor people in the hospital when they can not pay the full bill, so we are not able to and will not use this hospital again.

/s/ Carolyn Block
CAROLYN BLOCK

SUBSCRIBED AND SWORN TO before me this 24th day of May, 1971.

/s/ Rose M. Lowe
Notary Public

My Commission Expires. June 6, 1972

EXHIBIT 9

AFFIDAVIT

STATE OF WEST VIRGINIA

COUNTY OF BOONE, To-wit:

Howard Linville, of the Town of Fosterville, County of Boone, State of West Virginia, being duly sworn on his oath deposes and says:

1. That he is Treasurer of the Association of Disabled Miners and Widows, Inc.;

2. That the Association of Disabled Miners and Widows, Inc. is a non-profit corporation duly organized under the laws of West Virginia and having a membership of approximately 4,000 disabled miners and widows who reside in many states throughout the nation, including the Appalachian states of West Virginia, Kentucky, Pennsylvania, Ohio and Tennessee;

3. That the Association of Disabled Miners and Widows, Inc. is organized for the purpose of liberalizing pension benefits and enforcing proper rules and regulations under the United Mine Workers of America Welfare and Retirement Fund, as well as concerning itself as an organization with the related problems incident to member disabilities and infirmities;

4. That the member disabled miners and their widows are poor persons who are for the most part disabled miners or their widows with little or no outside income;

5. That the member disabled miners and their widows have no United Mine Workers of America hospital

cards, by which other members of UMW of A are afforded medical and hospital care for their health problems;

6. That the member disabled miners are persons who have spent many years in the most dangerous industry occupation in the United States, namely, the mining of coal, and that they are afflicted by a high incidence of traumatic injuries and disabilities as well as Pneumoconiosis of the lung (Black Lung) and that many of the members, including widows are elderly and, therefore, susceptible to the common and regular ailments of old age;

7. That low income status of the member disabled miners and their widows render them unable to pay hospital fees for the diagnosis and treatment of their various ailments;

8. That in individual cases member disabled miners and their widows have been unable to receive proper diagnosis and treatment, or even been turned away, from various private, non-profit hospitals throughout the region.

/s/ Howard Linville

Subscribed and sworn to before me this 27 day of Feb., 1972.

/s/ [Illegible]
County Clerk
Boone County,
West Virginia

My Commission expires:
12-31-72

EXHIBIT 10

AFFIDAVIT

I, Rosezella Cook, having been duly sworn do hereby depose and say:

1. I live at 2652 Alvar Street, New Orleans, Louisiana, where I have lived for the past seven years with my five children. This an apartment in the Florida Project of the Housing Authority of New Orleans.

2. My total family income for the five of us is $72.00, plus $160.00 per month for a housekeeper paid by the Welfare Department because of my health. We are so poor that I am unable to get the foods that doctors tell me to eat.

3. Four of my children are in school, and the fifth, an 18 year old boy has been looking, without success, for several months for a job. Unemployment is so high among young black men that he is becoming very discouraged.

4. My health has been very bad for several years now. From the Spring of 1970 I have tried to get treated for my high blood pressure, by the private hospitals in New Orleans, without success. Last year I was in public hospitals three times for several weeks at a time. The first two times I was in Charity Hospital. The third time I was hospitalized was in November 1972. This occurred when one day I had severe chest pains, and went to the Neighborhood health clinic. The doctor said I had to go right into the hospital. He thought I was having a mild heart attack. I told him I did not want to go to Charity Hospital, the local public hospital, because in my opinion, they were so overcrowded they are unable to give good treatment sometimes. The nurse called two hospitals to get me admitted but was unsuccessful. The

doctor then made special arrangements and got me admitted at the Public Health Hospital, where I stayed 27 days. I got good service there. I hope I and my children can get service there or at a private hospital in the future.

/s/ Rosezella Cook
ROSEZELLA COOK

Sworn to and subscribed before
me this 5 day of April, 1973

/s/ Elizabeth H. Z. Halstead
Notary Public

EXHIBIT 11

AFFIDAVIT

I, Monica Hunter, having been duly sworn do hereby depose and say:

1. I now reside at 3647 St. Ferdinand Street in New Orleans, Louisiana. I live there with my four children.

2. Our total family income to support the whole family is $90.00 a week from my job with New Orleans school system, as a tutor, plus $196.00 per month for Social Security survival benefits.

3. Two of my children, Craig, 15 and Dent, 11 are very sick with sickle cell anemia and require extensive medical care. Craig has had three sickle cell crises in the last years and Dent one. These can be very severe. For example, during Craig's last crisis, he was rushed to the hospital as an emergency patient. He was given I.V. transfusions, drugs, and oxygen and kept in the hospital for 12 hours. We took him to Charity Hospital because we are too poor for the voluntary hospitals. Charity, the state public hospital, treats us, but they are so overcrowded that we can never be sure we will get the treatment needed. Also, Charity is far away from us. There are two or three voluntary, tax-exempt hospitals that are closer and it would be important to use them when one of my children has a sickle cell crisis. However, we don't have the money needed at these hospitals.

4. In addition to the above, my family is forced to use Charity Hospital at a minimum of ten times a year for various things. I wish we could use a closer hospital, but we are too poor.

/s/ Mrs. Monica Hunter
MONICA HUNTER

Sworn to and subscribed before
me this 4 day of April, 1973

/s/ Elizabeth H. Z. Halstead
Notary Public

EXHIBIT 13

AFFIDAVIT OF RACHEL MILLER

I am the duly-elected President of the California Welfare Rights Organization (CWRO) and am authorized to make the following statements.

CWRO is an unincorporated, voluntary association of low-income persons in California. The organization is the state-wide affiliate of the National Welfare Rights Organization. Presently, CWRO has an active membership of approximately 3,000.

CWRO's members include recipients of every form of public welfare—Aid to Families with Dependent Children, Aid to the Needy Disabled, Aid to the Blind, Old Age Security, and General Assistance, as well as recipients of Food Stamps and Medi-Cal (Medicaid) benefits. Many of our members also receive Social Security, Medicare, Unemployment Insurance, and other social insurance benefits.

Not all of our members are recipients of public assistance or social insurance benefits. Many are simply poor persons unable adequately to provide for themselves and their families, yet ineligible for welfare because of restrictive eligibility conditions. Some of our members are former recipients who are still impoverished but have left the welfare rolls because of changes in governing laws, or the members' economic or other circumstances.

CWRO represents and seeks to protect the interests of its membership. CWRO actively asserts the rights of the poor to cash assistance, health and medical care, and all other forms of public aid. The organization attempts to change restrictive conditions and practices which close off the poor from the enjoyment of their statutory and constitutional rights to these benefits.

In representing the interests of its impoverished members, CWRO initiates litigation in the state and federal courts to obtain for the poor benefits conferred by law. CWRO's standing to litigate such issues is expressly recognized by the California Supreme Court in *CWRO* v. *Carleson*, 4 Cal.3d 445 (1971) and *County of Alameda* v. *Carleson*, 5 Cal.3d 730 (1971). In *CWRO* v. *Richardson*, 348 F.Supp. 491 (1972), the organization litigated its members' rights to health care benefits under federal law.

/s/ Rachel Miller
RACHEL MILLER

Subscribed and sworn to before me
this 31 day of March, 1973.

/s/ C. Robert Trentham
Notary Public

[SEAL]

OFFICIAL SEAL
C. ROBERT TRENTHAM
Notary Public—California
Los Angeles County
My Commission Expires Sept. 3, 1973

EXHIBIT 14

AFFIDAVIT

I, Marilyn G. Rose, being duly sworn, depose and state as follows:

1. I am Counsel of Record for Plaintiffs in the case of *Cook et al.* vs. *Ochsner Foundation Hospital et al.*, Civ. Act. No. 70-1969, E.D. La.

2. The attached, as described below, are true copies of Affidavits submitted by Plaintiffs in said case;

(a) Affidavits submitted in support of Motion for Preliminary Injunction (never heard) and resubmitted in support of Motion for Summary Judgment against Elliot Richardson as Secretary of Health, Education, and Welfare:

Exhibit A—Rosezella Cook
Exhibit B—Sallie Lee
Exhibit C—Monica Hunter
Exhibit D—Ora Pearl Price
Exhibit E—Merita Delores Moore
Exhibit F—Mary Jones
Exhibit G—Shirley Lampton
Exhibit H—Wilhemenia Brown
Exhibit I—Dr. Rob Robertson
Exhibit J—Jeffrey B. Schwartz and Clifford Breaux
Exhibit K—Edward Booker

(b) Affidavits submitted in support of Motion for Summary Judgment against Elliott Richardson as Secretary of Health, Education, and Welfare:

Dr. Albert J. Lauro
Dr. Rod Yeager
Dr. Charles C. Mary, Jr.
Raymond Downs, with attachments

3. In Appendix 6B of the Pre-trial Order Ochsner Foundation Hospital stipulated as fact to the following:

> "The records of Clifford Breaux show that he was an inpatient at Ochsner Foundation Hospital on two occasions, the first being in July, 1968 and the second occasion being in June, 1970. At the time of the first admission, a memorandum entitled "From the Desk of Clifford C. Losberg, Jr." states, "Earl—re Clifford Breaux. Will get $200 prior to admission & can come up with about $500 more in cash. Owns clothing store & oy (sic) clinic bills currently. Dr. Hatch says he will keep in 5 to 7 days, no more. L." He stayed in the Hospital 12 days. The statement for this hospital admission dated August 29, 1968 states that $482.85 was due, and further states "Sorry, but we cannot accept less than $100.00 a month. It is unusual for the Hospital to permit terms at all." At this time he had paid $50 in addition to the $200 at admission. Thereafter, Mr. Breaux paid this bill off, in monthly installments which ranged from $50 to $100. Mr. Breaux continued to be a patient at the chest clinic, being seen there on seven occasions between August 1968 and June 1970. On May 1, 1970 (the seventh occasion), the chest clinic record states: "This patient needs to be hospitalized and he can't afford OFH. Will write a letter to Charity Hospital and hope they will take him. /s/ Hatch, M.D.X." The next record indicates that he was admitted June 11, 1970 and died on the morning of June 22, 1970. The diagnosis on autopsy shows the following conditions:
>
> 1. extreme obesity
> 2. bleeding duodenal ulcer, w/massive hemorrhage in GI tract
> 3. multiple pulmonary thromboemboli bilaterally

> 4. congestive heart failure, w/cardiomegaly
> 5. mural thrombi, right auricle & ventricle
> 6. anascarca (edema all over)
> 7. congestion of lungs and liver
> 8. adrenal cortical nodular hyperplasis
> 9. thrombosis of the periprotatic venis
> 10. adenomata of the colonic mucosa
> 11. prostatic calculi
> 12. mild diabetes mellitus, "clinically."

subparagraph c(34)

/s/ Marilyn G. Rose
MARILYN G. ROSE
Washington Counsel
Health Law Program
733 - 15th St., N.W.
Room 236
Washington, D. C. 20005
(202) 783-1666

Sworn to and subscribed before me this 10th day of April, 1973.

/s/ Justin V. O'Conor
JUSTIN V. O'CONOR
Notary Public
My Commission Expires May 11, 1974

EXHIBIT A

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Rosezella Cook, who declared under oath that:

1. I am a female, 33 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2652 Alvar Street in the Florida Housing Project of the Housing Authority of New Orleans. I live there with my six children for whom I am sole support.

3. My family income is derived from a monthly welfare check totaling $73 per month. My family does not receive any other source of income. Welfare also pays $160 for a full time house keeper since I am so ill I can do no house work and need full time care.

4. I am suffering from a heart condition, high blood pressure and extreme nervousness.

5. I am eligible to receive treatment for my condition at Charity Hospital. For several years, I have been going to Charity Hospital's out patient medical clinic every two weeks to receive medicine for my condition. These drugs have not helped me, and in fact, my condition has worsened considerably. I was admitted into Charity Hospital on April 2, 1970, because my blood pressure had risen to 26/146. I was released from Charity Hospital on April 17, 1970, but the treatment I received did not help me.

6. In need of treatment, and knowing that the drugs I have been receiving at Charity Hospital have not helped one, I decided to go to Methodist Hospital, 5620 Read Road, which is reasonably close to my home, to see if they would treat me.

7. On June 28, 1970, I went to Methodist Hospital and asked to be seen. I told the admit clerk that I was suffering from very high blood pressure and a chronic heart ailment. I also told her that I was a welfare recipient. The clerk told me that I would have to pay $10 just to be seen in the emergency room and that a total deposit of $35 was required, since the total bill with tests would amount to at least $35. The admit clerk also said that I cannot be accepted even if I borrow the required deposit, since it would take too much out of my welfare check. I could not be seen at Methodist Hospital because of my poverty.

8. I am in desperate need of treatment for my condition. I have no money to receive the necessary medical treatment I need. The treatment I have received at Charity Hospital has not helped me. I have nowhere to turn.

/s/ Rosezella Cook
ROSEZELLA COOK

Sworn to and Subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life

EXHIBIT B

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Sallie Lee, who declared under oath that:

1. I am a female, 48 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2814 Alvar Street, Apartment C, in the Desire Housing Project of the Housing Authority of New Orleans. I live there with my six children for whom I am sole support.

3. Our total income for the seven of us is $244 monthly, of which $32 per week is derived from part time employment as a health worker in a Total Community Action training program and $116 per month is derived from welfare payments. My family does not have any other sources of income. Because of our extreme poverty, my family also is eligible for and receives food stamps, federal assistance through public housing for shelter, and federal assistance for medical services through the Medicaid Program.

4. For many years, I have been suffering from a severe case of arthritis and from high blood pressure.

5. I am eligible for and have received treatment for my condition at Charity Hospital. The treatment I have received there has not helped me and my condition has worsened most recently.

6. Being in desperate need of treatment and having received no results at Charity Hospital, I decided to make

an attempt to be seen at the Ochsner Clinic, because I was told that the doctors there are very good and would be able to help me.

7. On June 29, 1970, I went to Ochsner Clinic where a nurse opened a file in my name. It was noted that I was a welfare recipient. I was then sent to the emergency room of Ochsner Hospital. I spoke to a nurse in the emergency room and told her that I was very ill and needed treatment. The nurse told me that a $35 deposit would be required before I could be seen, but since I was a welfare recipient, I could not be seen even if I borrowed money or sacrificed some of my welfare money to pay the required deposit. I told the nurse I could pay the deposit, but she again said that I couldn't be treated. The nurse then sent me back to the Clinic, but she said they probably wouldn't see me there either since I was a welfare recipient. I returned to the Ochsner Clinic where a nurse asked me what my income was. I told her that I was a welfare recipient, but she said welfare is not income and that I was too poor to qualify for treatment at Ochsner Clinic. I asked the nurse if she could recommend me to someone else, but she said the only hospital I can advise you to go to is Charity Hospital.

8. I am a very sick woman. The treatment I have received at Charity Hospital has been of no help to me. I need immediate and proper treatment for my condition.

/s/ Miss Sallie Lee
SALLIE LEE

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT C

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Monica Hunter, having been duly sworn, do hereby depose and say:

1. I am an adult, black, female and a citizen of Louisiana and the United States.

2. I reside at 416 North Villere Street in the Iberville Housing Project of the Housing Authority of New Orleans. I live there with my four children for whom I am the sole support. My husband died several years ago.

3. Our income for the five of us is $147 primarily from my husband's social security benefits. Because we are so desperately poor, we also are eligible for and do receive food stamps, federal assistance through public housing for shelter, and federal assistance for medical services through the Medicaid Program.

4. Over the past month or more I have been having pains in my lower abdomen and headaches. About a month ago, I went to Charity Hospital and was told I had a kidney infection and given certain medicine. Although I took this medicine as directed, I have felt no better. In fact, I have been getting progressively worse.

5. On Saturday night, June 20, 1970, I was in severe pain. I could not sleep all night. Because of this, I went to Charity Hospital first thing Sunday morning and was there at 8 o'clock. The doctor there told me that I did not have a kidney infection that I had something else and he gave me some other medicine. I have taken that medicine this week without any relief.

6. The pains in my lower abdomen are very severe, although, fortunately, they are not continuous and come and go. The pressure and pain in my head are getting worse, and I am really frightened that I have some serious illness. I believe that I need several elaborate and extensive medical tests to determine exactly what is the matter with me and full medical treatment, possibly hospitalization.

7. Because I know that Charity Hospital is so overcrowded and does not admit patients or give the full tests because they do not have adequate funding, I decided to try to get other medical care. On Friday, June 26, 1970, I went to Methodist Hospital, 5620 Read Road, hopefully to get medical treatment. I was told by the receptionist at the hospital that the hospital was a private one for private patients only. I was told that I must have a doctor. I was also told that they might call one of the doctors on the staff for me if I would pay $25 in advance or if I had a Bankamericard or a Master Charge card. I told the receptionist that this was ridiculous because I was a social security recipient. I told her that I was on Medicaid and that my hospital bills would be paid through that program. Still, they would not help me at Methodist Hospital.

8. I then went to the Hotel Dieu Hospital in an attempt to get medical treatment. I was told at this hospital that they only treated private patients since it was a private hospital. They would not even allow me to see a doctor. I must have a private doctor in order to get into the hospital. Further, I would have to pay for any medical treatment. My medicaid program would not be accepted. Of course, I cannot afford a private doctor and that is why I am seeking help at hospitals. Still, they would not help me.

9. Having been unable to get any medical treatment elsewhere, I guess I will have to go back to Charity al-

though I know they are not taking care of me. I wish there was some way I could get medical assistance. I am very worried about my health.

/s/ Mrs. Monica Hunter
MONICA HUNTER

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT D

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before me, Notary, appeared the undersigned, Ora Pearl Price, who declared under oath that:

1. I am a female, 46 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 3703 Benefit Street, Apartment C, New Orleans, Louisiana, where I live with my thirteen children and my disabled and unemployed husband.

3. My family's income is derived from a monthly welfare payment of $134.00 and monthly social security checks for my husband and my children totaling $262.00. My family does not have any other sources of income.

4. For the past several years I have been suffering from a stomach ailment which has caused severe nauseation, and I have also been suffering from obesity and high blood pressure.

5. I am eligible for Medicaid benefits. Since 1956 I have been going to Charity's out-patient clinic where I have had my blood pressure tested. In 1964 I was admitted into Charity Hospital for a hernia infection but was not operated on.

6. In March 1970, I went to Charity Hospital to again have my blood pressure tested. At that time, the residing physician told me not to come back to Charity Hospital until I lost thirty pounds.

7. During the past few weeks, I have become severely nauseated several times and my stomach pains have intensified. Afraid I wouldn't be seen at Charity Hospital because I hadn't lost thirty pounds, I decided to make an attempt to be examined and hopefully admitted into Touro Infirmary. I decided to go to Touro Infirmary since I was treated there in 1954.

8. On June 29, 1970 I went to Touro Infirmary in order to get treatment for my condition. I first went to the in-patient admitting desk. I went to the emergency room and there told the clerk I was ill and wished to be examined by a physician. I also told her that I was poor and unable to pay any fees. She told me that I would have to pay $35.00 for a physician to examine me and that I would have to pay in advance for all tests to be performed. Unable to pay the required fees, I left Touro Infirmary without receiving any treatment.

9. My sickness has worsened steadily in the past few weeks. I am in need of medical treatment but I am unable to pay for hospital or doctor fees. The treatment I received at Charity Hospital has not cured, or even helped my ailments.

/s/ Ora Pearl Price
ORA PEARL PRICE

Sworn to and subscribed before me this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT E

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Merita Delores Moore, who declared under oath that:

1. I am a female, 29 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 5320 Florida Avenue, New Orleans, Louisiana, where I live with my three children, ages 12, 10, and 5. I am the sole support of these three minors.

3. My income is derived solely from welfare payment, such income amounting to $110 per month.

4. During the past few months, I have been suffering severe stomach pains and I also have been suffering from a chronic heart ailment.

5. Because I have no money whatsoever to pay a private physician, I have been going to Charity Hospital's outpatient clinic for the treatment of my condition. I last visited Charity Hospital in March, when at that time, after waiting an unreasonable period of time to be seen, I was given some pills for my stomach ailment and sent home.

6. Since March, and especially during the past few weeks, my condition has worsened considerably. The pains in my stomach have become unbearable.

7. On June 29, 1970, I decided to go to Flint-Goodridge Hospital to see if I could get treatment for my condition. I spoke to the clerk at the admitting desk who asked me if I had the recommendation of a private physician. Upon telling her that I didn't know a private physician, she recommended that I contact one of three specified doctors in the New Orleans Medical Association. I then asked the admit clerk if I would have to pay for hospital services provided by one of the above named physicians. I told her that I was unable to pay for any hospital treatment, including a deposit, since I was a welfare recipient with a meager income. The clerk then informed me that it was a hospital requirement that I pay a $250 deposit if I was to be admitted into the hospital as well as any other costs incurred while I was an in-patient at the hospital. She said the only exception to this deposit requirement, was if I could produce proof of hospitalization insurance. Having no hospital insurance and being unable to afford the required $250 deposit, I left Flint-Goodridge Hospital without being examined.

8. The drugs I received at Charity Hospital have not helped cure my stomach ailment. I have no money to receive the necessary medical treatment I need.

/s/ Merita Delores Moore
MERITA DELORES MOORE

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
Notary Public
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT F

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Mary Jones, who declared under oath that:

1. I am a female, 44 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is 3719 Benefit Street, Apt. B, New Orleans, Louisiana where I live with my disabled husband, and thirteen of my fourteen children.

3. My family income is derived from a monthly welfare check totaling $263 and monthly social security checks for my husband and my children totaling $148. My family does not have any other sources of income.

4. I am suffering from an acute kidney condition, high-blood pressure, obesity, excess fluids and extreme nervousness.

5. I am eligible to receive treatment for my condition at Charity Hospital. For several years, I have been going to Charity Hospital for treatment with my most recent visit made in January, 1970. Several times I have asked to be admitted into the hospital, but each time I have been given pills for my kidney infection, nervousness, and high blood-pressure and then told to return home.

6. My condition has worsened in the past few days and hoping to be admitted into a hospital, I decided to go to Sara Mayo Hospital on the recommendation of a friend. I did not go back to Charity Hospital, because

I feared they would once again give me some pills for my ailments and then send me home. The drugs they have given me at Charity Hospital have not helped my condition.

7. On June 29, 1970 I went to Sara Mayo Hospital and there I spoke to a clerk at the admitting desk. I told her I was ill and that I wished to see a doctor. I also told her that I was unable to pay any physician's or hospital fees because of my meager income. The clerk told me that there was no physicians on duty at the hospital, but if I paid a deposit due immediately she would phone a physician who would see me. Since I had absolutely no money to pay the deposit, I left Sara Mayo Hospital without being examined or treated for my condition.

8. I am a very sick woman. The drugs given to me at Charity Hospital have been of no help. I feel that I should be admitted into a hospital for proper treatment of my condition.

/s/ Mary Jones
MARY JONES

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT G

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, a Notary, appeared the undersigned, Shirley Lampton, who declared under oath that:

1. I am a female, 29 years old and black. I reside in the Parish of Orleans and I am a citizen of the State of Louisiana and the United States.

2. My present residence is at 2526 Mazant Street, Apartment E, in the Florida Housing Project of the Housing Authority of New Orleans. I live there with my seven children for whom I am sole support.

3. My family income is derived from a monthly welfare check totaling $137 per month. My family does not receive any other source of income.

4. I am suffering from severe and at times unbearable stomach pains.

5. I am eligible to receive treatment for my condition at Charity Hospital. During the last week the pains in my stomach became more severe and I decided to go to Charity Hospital on the evening of July 6, 1970. I spoke to a physician there who only examined my urine and told me to come back if the pains became worse. The pains in my stomach continued to grow worse and I returned to Charity Hospital the next evening, July 7, 1970. At that time I was examined and given some drugs for my stomach.

6. I believe that my stomach pains have resulted from female troubles and that I need a thorough examination and possibly an operation to stop these pains which continue to plague me.

7. I fear that I wasn't receiving adequate treatment at Charity Hospital because of overcrowded operating rooms and insufficient blood supply for elective, but necessary surgery, I decided to go to Mercy Hospital, 301 North Jefferson Davis Parkway to see if I could undergo an examination in order to help cure my abdominal disorder. On July 9, 1970 I went to Mercy Hospital's information desk and asked if I could see a doctor. The receptionist told me to go to the emergency room. I went to the emergency room and spoke to a nurse there. I told her I was ill and wished to see a doctor. I also told her that I was poor and could not afford to pay for any hospital costs. She told me that in order to be seen at Mercy Hospital, I would need my own doctor or if I had a sufficient amount of money, she would call a doctor for me. She said if you have no money, you must go elsewhere. Being without money, I left Mercy Hospital without being examined.

8. I am a desperately sick woman. I fear that I will need more treatment including a possible operation for my condition. The treatment I received at Charity Hospital has not cured my illness. I do not know where to turn.

/s/ Shirley Lampton
SHIRLEY LAMPTON

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT H

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before Me, a Notary, appeared the undersigned, Wilhemenia Brown, who declared under oath that:

1. I am a female, 28 years old and black. I reside in the Parish of Orleans and am a citizen of the United States and of the State of Louisiana.

2. I reside at 1855 Whitney Avenue in the Algiers-Fischer Public Housing Project. I live there with my two children, Anthony, age 11 and Arthur, age 9.

3. Our family's income is derived from $43.00 per month under Louisiana's Aid to Dependent Children Public Welfare Program and $64 per month in support payments from my divorced husband. I have been receiving the support payments very irregularly and have been in court in an attempt to have the payments made on time. As a practical matter, my total income in the last month or two has been $43 a month. I am supposed to get a raise in my welfare grant soon.

4. I have been feeling ill recently and have had pains in my left side. I am concerned about them and have a feeling it might be a kidney infection.

5. In order to get medical treatment, I recently went with my sister to West Jefferson Hospital to seek medical assistance. We went on July 8, 1970, and upon arriving, asked to see a doctor. The receptionist first asked if we had any insurance and a private doctor. I told her that I had no insurance other than under the medicaid program and I did not have a private doctor. She said

that we could not be treated there, but she still had us fill out applications and took us to see a doctor.

6. The doctor explained to us that we could not be treated at the hospital because we did not have a private physician and because we did not have insurance and because we did not have money to pay for the services received or to pay the initial deposit.

7. Because I did not have the money, there was no way for me to get the treatment I needed at this hospital so I left.

/s/ Wilhemenia Brown
WILHEMENIA BROWN

Sworn to and Subscribed before me
this 22nd day of July, 1970.

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT I

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Dr. Rob Robertson, do hereby depose and say:

1. I am a Doctor of Medicine and an intern on the medical staff of Charity Hospital.

2. On May 29, 1970, I saw the patient, Clifford Breaux, while I was working in the Admittance Room of Charity Hospital.

3. When I saw the patient, he was tremendously obese; he had 4+ edema to above knees, presacral region, abdominal wall, and both hands. There were scattered posterior basilar rales in thorax and a fluid wave across abdomen on percussion. He was slightly dyspneic at rest. X-rays were insufficient because of technical difficulties in positioning patient who was unable to stand by himself. Patient weighed in excess of 425 pounds—the maximum of the hospital scale.

4. It was my opinion that the patient should be immediately admitted to the hospital. However, due to insufficient beds in Charity Hospital, patient was not admitted.

/s/ Rob Robertson
DR. ROB ROBERTSON, M.D.

Sworn to and Subscribed before me
this 15th day of June, 1970

/s/ James E. Young, Jr.
JAMES E. YOUNG, JR.
Notary Public,
Parish of Orleans, State of La.
My Commission is issued for life.

EXHIBIT J

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Jeffrey B. Schwartz, having been duly sworn, depose and say,

1. I am one of the attorneys in the lawsuit, *Rosezella Cook, et. al.* vs. *Ochsner Foundation, et. al.*

2. In connection with said lawsuit, our law office was contacted by the family of Clifford Breaux. Subsequently, Mark Rudy, another attorney in this lawsuit, and I had several conversations and interviews with Clifford Breaux and members of his family with a view towards his becoming a named Plaintiff in this action in order that he could obtain the medical treatment he needed.

3. The attached Affidavit was prepared for use in this litigation. However, Mr. Breaux died before the attached Affidavit could be executed. The Affidavit is true and correct to the best of my information and belief.

/s/ Jeffrey B. Schwartz
JEFFREY B. SCHWARTZ

Sworn to and Subscribed before me
this 20th day of July, 1970

/s/ James E. Young, Jr.
Notary Public

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, a Notary, appeared the undersigned, Clifford Breaux, who declared under oath that:

1. I am a male, 58 years old, and black. My present residence is 2605 Philip Street, New Orleans, Louisiana. I am a resident of Orleans Parish and a citizen of the State of Louisiana and the United States.

2. I am eligible for health services provided by Charity Hospital at New Orleans. I am self-employed at Cliff and Dot's Restaurant, 2601 Philip Street, New Orleans, Louisiana. For at least the past year, I have been too ill to run the store. Because of this, the store has been operating at a loss. My wife had to give up work to run the store. We are desperately poor; we can hardly afford to subsist and certainly cannot afford the expenses of hospitalization and medical treatment.

3. I am not eligible for Medicare payments because I have not reached the age of 65. I am not eligible for Medicaid payments in the State of Louisiana, because I am self-employed and I am not receiving welfare payments, or aid to the blind, aged or disabled.

4. I can only afford to go to Charity Hospital for treatment of my condition, since because of my small income, I cannot afford the deposit required and charges assessed by most other hospitals in Orleans Parish.

5. I am suffering from extreme obesity, shortness of breath, and congestive heart failure. I have been chronically ill since 1966, and because of my condition I have had great difficulty moving around. In 1966 I was a

patient for 13 days at Ochsner Foundation Hospital where I received treatment for my condition.

6. In the past few months my condition has worsened considerably. Since May 5, 1970, I have attempted to be admitted into Charity Hospital on five different occasions. On each occasion I was not admitted into the hospital.

7. On June 1, 1970, accompanied by my brother, Paul Breaux, I went to Charity Hospital for a clinic visit. At that time, I asked the physician present if I could be admitted into the hospital because of my condition, but he gave me a prescription for drugs to treat my ailment, and told me to return to the hospital on June 8, 1970.

8. On June 8, 1970, showing no improvement in my condition, I went to Charity Hospital for my clinic visit. Once again, I was given some drugs to treat my illness and told to return home.

9. On June 10, 1970 my condition became markedly worse. I began suffering extreme body pains, had much difficulty breathing and was unable to digest my food. I felt that I needed immediate hospital care. My brother, Paul Breaux, attempted without success to have me admitted as a non-paying emergency patient at Alton Ochsner Foundation Hospital, Touro Infirmary, and Flint-Goodridge Hospitals. I did not attempt to be admitted into Charity Hospital, since I had been previously refused admittance several times at that hospital and I did not want to risk further harm to myself by making a futile trip to Charity Hospital.

10. During the night of June 10, 1970 and early morning of June 11, 1970 I suffered a further relapse in my condition. My situation becoming more desperate, my brother, Paul Breaux, and my wife, Dorothy, managed to borrow the $200.00 needed as a deposit in order to be admitted into Alton Ochsner Foundation Hospital.

11. I am presently an in-patient at Oschner Hospital. I am financially unable to pay any of the costs for my treatment at this hospital.

12. I am a chronically ill man, and I am in need of hospital care in order to receive the necessary treatment for my condition.

13. Even after I am released from Ochsner, I will need continuing medical care which I will not be able to get because of my poverty.

[Unsigned]
CLIFFORD BREAUX
2603 Philip Street
New Orleans, Louisiana 70113

Sworn to and subscribed before me
this —— day of ———, 1970.

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF ORLEANS

Before me, a Notary, appeared the undersigned, Edward Booker, who declared under oath that:

1. I am a male residing in the Parish of Orleans at 2805 Clara Street, Apartment F. I am a citizen of the State of Louisiana and the United States.

2. I am the son of Mrs. Catherine Booker, (deceased), whom I resided with at 2805 Clara Street, Apartment F, New Orleans, Louisiana, before her death at age 47.

3. Before her death, my mother suffered from an acute chronic asthma condition, congestive heart failure, high blood pressure, and a nervous disorder. Further, she suffered from extreme obesity, weighing nearly 300 pounds at her death.

4. My deceased mother, Catherine Booker, was eligible for treatment at Charity Hospital. She was a welfare recipient, and being desperately poor, she was forced to go to Charity Hospital as the only means to receive the necessary treatment for her condition, since she could not afford the required deposit and costs for needed treatment at other hospitals in Orleans Parish.

5. For several months prior to her death, my brothers Alfred Booker and John S. Booker, III and I attempted to have my mother admitted into Charity Hospital. During that time her condition had worsened considerably; she complained of severe stomach pains, shortness of breath, and because of her weight problem, she had much difficulty moving about. I took her to Charity on the following days: October 16, 1969, December 20, 1969, February 19, 1970, March 8, 1970, and March 22, 1970.

Each time I took my mother to Charity Hospital, she was refused admittance, and I was forced to take her home, since neither my brothers nor I could afford to take her to another hospital. During her last few months of life, my mother visited some private physicians who stated that they thought that she should be admitted into a hospital.

6. During the early morning hours of March 23, 1970 my mothers condition took an abrupt turn for the worse. She had extreme difficulty breathing and at 4:00 A.M. I took her to Charity Hospital, but again she was refused admittance and told to go home. Believing my mother to be near death, later that morning, I called Flint-Goodridge Hospital to see if I could have my mother admitted there. I explained to the clerk that my mother was gravely ill and needed immediate care and that the little treatment given to her at Charity Hospital had not helped her. The clerk said a $325 deposit and the recommendation of a physician was needed before my mother would be admitted into Flint-Goodridge Hospital. I told her I couldn't afford to pay the deposit but she said this was a required amount and no exceptions would be made. I then attempted to borrow some money in order that I could have my mother admitted into Flint-Goodridge Hospital. I was unsuccessful in borrowing the money needed to have her admitted into Flint-Goodridge Hospital.

7. My mother's condition continued to worsen and in the afternoon of March 23, 1970 I again took my mother to Charity Hospital. I attempted to have her admitted twice during the afternoon, but each time she was refused admittance because of the lack of available beds at Charity Hospital.

8. On the evening of March 23, 1970, I decided to call Charity Hospital and attempt to have an ambulance from

that hospital take my mother back to the hospital. At this time, my mother was desperately gasping for breath and seemed to be semiconscious. The ambulance came and my mother was administered oxygen and told to walk down to the ambulance, since ambulance drivers supposedly do not carry patients up and down stairs.

9. My mother accompanied by my brother, Alfred Booker and John S. Booker, III, and my sister Merian Booker went to Charity Hospital by ambulance on the evening of March 23, 1970. I was too upset over my mother's condition and my futile efforts to get her proper treatment and thus couldn't accompany my mother to Charity Hospital. My mother was finally admitted into Ward E-508. She was given a larger tank of oxygen, but her condition continued to worsen; she could no longer speak and had great difficulty breathing. She died in the early morning of March 24, 1970 about one hour after finally being admitted into Charity Hospital.

10. I firmly believe that if given the proper treatment, my mother would still be living today. Since my mother was desperately poor, she could not afford to receive treatment at any other hospital except for Charity Hospital, where the treatment she received was both too little and too late.

/s/ Edward Booker
EDWARD BOOKER

Sworn to and subscribed before me
this 20th day of July, 1970.

/s/ James E. Young, Jr.
Notary Public

AFFIDAVIT OF DR. ALBERT J. LAURO

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Albert J. Lauro, being duly sworn did depose and state as follows:

1) I am a Senior Staff Supervisor of the Acute Emergency Room at Charity Hospital of Louisiana in New Orleans.

2) Credentials are as follows:

Louisiana State University School of Medicine—M.D. Degree, 1951

Internship at Mercy Hospital 1955

Residency in Internal Medicine at Charity Hospital of Louisiana at New Orleans 1956-1958

Visiting (Sr.) physician and parttime staff, Charity Hospital of Louisiana at New Orleans, 1958-1969

Louisiana State University School of Medicine: Instructor 1956-1958

Assistant Professor of Medicine 1958 to date

Private practice—parttime until 1969

3) As one of the six Senior Staff Supervisors of the Acute Emergency Service at Charity Hospital. I supervise the interns and residents assigned to that service and the decisions which each must make on whether a patient gets admitted on inpatient status or treated on ambulatory basis. In a borderline situation, I personally have the responsibility to make the decision as to whether to admit a patient.

4) Approximately 35 to 50 patients a day get referred to outpatient clinics for treatment, who, in my opinion and based upon my experience as a private practitioner in New Orleans, would get admitted as inpatients at private hospitals and would be admitted to Charity if we had the facilities.

5) For approximately a year (during 1970) records were periodically made documenting patients who were referred to ambulatory (outpatient) treatment rather than admitted as inpatients. Since then, we have made spot checks, and from these spot checks and my personal knowledge and experience of the acute emergency service, the number of patients who are not admitted as inpatients who would be admitted with similar conditions at private hospitals is approximately the same today as when the periodic records were kept.

6) For example, on Sunday, April 16, 1972, I made a spot check of the persons classified as "elective" surgery who were turned away from inpatient admission who should have been admitted. There were 26 such cases, including one with masses of the breast and one with gallstones. On this particular day there were already five patients on roller beds in the surgical ward causing severe overcrowding and consequently no additional patients were admitted.

7) Some of the common types of cases which are not given inpatient care who should, in my professional opinion, be admitted but are referred to ambulatory treatment are:

a) stroke victims: Many persons suffering from strokes are not admitted but are sent home with symptoms such as weakness in an arm. Three days later some of these patients will come back with full paralysis on one side. I would always admit such a patient for 72 hours observation in the private practice situation and

under these inpatient conditions might well be able to prevent adverse developments;

b) impending infarction (impending heart attack): It is very unfortunate to have to send such persons home but under the overcrowded conditions at Charity it occurs;

c) ulcers: Not actively bleeding, but with anemia;

d) masses in the lung (which may be cancer or TB);

e) uncontrolled hypertension with blood pressure over 200/Over 140. Such patients are given an injection on a roller bed and watched possibly for 24 hours and then sent home without being admitted into inpatient status. We do not know if the patient soon thereafter would go into shock or whether his or her blood pressure shoots back up.

These are the conditions I see every day; there are others.

8) There are many things lost to a patient who is given ambulatory treatment and then sent home rather than be admitted as an inpatient;

a) there is a delay in diagnosis, which may be critical;

b) his treatment is not being supervised, e.g., the effects of medicine upon his system is not under surveillance for 24 hour periods if he is not an inpatient;

c) the patient may have adverse reaction but have a problem getting an ambulance and not come to the hospital;

d) poor people may be better off in a hospital because of communication problems concerning effects of treatment.

9) One of the critical problems is the shortage of beds. In many instances halls are used as wards with patients

in roller beds. Some interns and residents have patients they are treating that are scattered all over the facility and this decreases efficiency and in emergency situations can be extremely detrimental to the patients health.

10) The private hospitals in the New Orleans area had bed shortages prior to 1969, but things have been greatly improved since Methodist opened and West Jefferson increased substantially the number of beds. As of 1969, I was able to place my private patients in Mercy (where I had staff privileges) whenever I called for space. Comparably, things are worse at Charity from what they were in 1969 with respect to available beds for persons needing inpatient admission.

11) In addition to the patients whom we cannot admit from the emergency room there are patients we do admit, but once they get transferred to the wards they are released by the resident in charge in the ward because of serious overcrowding in the ward. On one occasion this past winter I had to threaten a resident with sanctions if he did not admit a patient into his service whom we had admitted. These residents are under a severe strain since they no more want to turn persons away anymore than we do, but they have a severe shortage of space. Dr. Jaime Olle, for example, has a 12 bed assignment, but in fact has 46 patients scattered throughout the hospital.

12) Some four or five months ago, I personally called Dr. Hyman at Sara Mayo and the administrator at South Jefferson Hospital and asked them to take some Medicare patients and forget the deductible. Both said they would be unable to do it. I had intended to call all the private hospitals with a similar request, but after these two hospitals looked into the matter and stated

they were unable, I felt it would be fruitless to call any others.

/s/ Albert J. Lauro
DR. ALBERT J. LAURO

Sworn to and Subscribed before me
this the 31st day of May, 1972.

/s/ [Illegible]
Notary Public

AFFIDAVIT OF DR. ROD YEAGER

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Rod Yeager, being duly sworn, did depose and state as follows:

1. As of July 1, 1972, I became head of the Section of Cardiac Surgery at Louisiana State University Medical School in Shreveport, Louisiana. I have the title of Assistant Professor.

2. Prior to July 1, 1972, I was the Chief Resident of Thorastic Surgery at Charity Hospital of Louisiana at New Orleans.

3. My credentials are as follows:

Tulane Medical School, M.D. degree, 1965

Internship at Charity Hospital of Louisiana at New Orleans 1965-1966

Surgery Resident for six years at Charity Hospital of Louisiana at New Orleans 1966-1972

Chief Resident—Tulane General Surgery 1970-1971

Chief Resident of Thorastic Surgery 1971-1972

4. From my experience as a resident in surgery at Charity Hospital, the shortage of bed capacity has meant that many persons needing elective surgery cannot get into the hospital, or get into the hospital in very limited numbers after a long wait.

5. The conditions which I include in elective surgery are such conditions as the following: hernia, ulcers (peptic), gall bladder, varicose veins, hysterectomies, breast masses (which may or may not be malignant).

6. The failure for these patients to be admitted means that they are in constant "misery" and, in many cases, cannot work and must remain on welfare. An example of the letter are cases of hernia which render men disabled and place them on the welfare roles; if these men could get the operation (which is elective) they could go back to work.

7. The surgery service from which I supervised has four residents in addition to the supervisor. These residents keep a list of "pre-operative" patients, i.e., patients who have been worked up in clinic and are ready for elective surgery, but have not been admitted for the surgery because of lack of beds. From my experience at any given time each of the residents will have at least 20 patients in this category.

8. On June 29, 1972, I met with Marilyn G. Rose, one of the attorneys for the plaintiffs in the case *Cook et al.* vs. *Ochsner Foundation Hospital, et al.* After explaining the above problems to her, I called one of the residents who worked under me to the office at Charity Hospital and asked him to look at his pre-operative list and tell us how many patients on that list were awaiting admission for elective surgery. He counted 60. He had the Charity record numbers of 50 of these patients listed. This resident's name is Dr. Max Kappelman, a third year resident in surgery. From my experience as a surgery resident and as Chief surgery supervisor, the conditions of these patients and the period which they had been awaiting surgery would be representative of the records of all the residents for at least the last two years.

9. The private hospitals in the New Orleans area transfer patients to Charity Hospital. When a patient who has been operated upon, usually because of trauma, at the other hospital, the transfer may be a medical problem. In certain circumstances the practices and pro-

cedures followed at the other hospital may be different from those which we would have followed at Charity. (This difference is not a difference in quality, but a difference in approach). The difference affects the continuity of treatment. In addition the medical workup and history is often lacking of incompleteness. Delays in treatment result from the disruption of treatment and the incompleteness of the record, and this can be medically detrimental to the patient.

10. Twice within recent months a patient in trauma was operated upon in another hospital where he arrived in an emergency condition and then transferred from the recovery room to Charity Hospital.

DR. ROD YEAGER

Sworn to and Subscribed before me
this —— day of June, 1972

Notary Public

AFFIDAVIT OF DR. CHARLES C. MARY, JR.

I, Charles C. Mary, Jr., being duly sworn, did depose and state as follows:

1.) I am Director of Charity Hospital of Louisiana in New Orleans, having been appointed to that position effective January 1, 1970.

2.) Credentials are as follows:

Loyola University of the South—B.S. Degree—1958

Louisiana State University of Medicine—M.D. Degree—1961

Tulane School of Public Health (Medical Administration) 1969

Director of Professional Services at Charity Hospital—1969

Director of Medical Education and Charity Hospital Schools—1968

Director of Medical Intensive Care Unit at Charity Hospital—1966-68

Associate Director of Charity Hospital—1966-69

Assistant Clinical Director of Charity Hospital—1964-65

3.) As Director of Charity Hospital, I am the chief operating officer of the hospital, with final responsibility for carrying out the hospital's mandate to provide medical care to the indigent of Louisiana.

4.) The medical services available to the indigent population of the New Orleans Metropolitan area, which consist overwhelmingly of services provided by Charity Hospital, fall markedly short of meeting the health needs of this indigent population. The reasons for this failure

are lack of funds with resulting lack of personnel and a limitation of physical facilities.

5.) Despite these deficiencies in faculties, those patients that Charity Hospital does in fact serve do receive good quality of care. This high quality of care is a direct result of the excellent medical staff, which includes professors and teachers at Louisiana State and Tulane Universities Schools of Medicine and Louisiana State School of Dentistry. However, the main thrust of Charity Hospital's efforts in caring for the poor is crises intervention and treatment of acute and chronic illnesses. Limitations in facilities and overwhelming numbers of patients with acute illnesses have to date prevented adequate comprehensive programs in preventive medicine, eye, dental and health education. In the past two years, 1970-72, there have been increasing numbers of indigent patients seeking care from Charity Hospital. Outpatient visits in:

1970—813,000 visits
1971—854,000 visits
1972 projected—980,000 visits

In order to maintain the high level of inpatient care and to keep up with increasing costs of hospitalization, the hospital was forced to reduce beds in 1970 which has resulted in patients being denied admission and being treated as outpatients. Charity Hospital has been forced during the time of my tenure, including to the present date, to refuse inpatient care to an average of 20 to 25 patients per day and as high as 50 patients on certain days. This determination regarding care and treatment is based on option of medical officers using admission standards of a private hospital.

6.) Charity Hospital is forced to render outpatient care in overcrowded and overtaxed facilities where every seat is taken and standing room is not unusual.

7.) In addition, with respect to outpatient facilities, the limitation in the number of examining rooms results in make-shift arrangements at which patient privacy is at a premium. With respect to inpatient services, frequently patients who are admitted are placed on roller beds because of the lack of available hospital beds.

8.) As set forth above the existing medical services in the New Orleans metropolitan area fall short of meeting the needs for services requested by the poor presenting themselves for treatment. This, however, is only a portion of the actual medical services needed by the poor. If medical services were made available substantial additional poor people would receive treatment and consequently be healthier and more productive citizens.

9.) One example of documenting this statement was the extensive demand and unexpected inundation of a conveniently placed satellite clinic in the Desire area. In 1969 Charity Hospital opened an outreach clinic in the Desire Project Area in the Ninth Ward of the City of New Orleans. This clinic is open in the afternoons on Monday through Friday and at the present time serves 1,200 patients per month. In spite of this additional service, many more patients seek service in the clinic than can adequately be handled at the present time and expansion of services in this area is necessary. Additional satellite clinics have further demonstrated that there are large numbers of indigent patients who do not seek care at the main facility, perhaps because of reason of inconvenience of distance, time and family responsibilities as well as inaccessibility of care and low awareness amount the poor of the value of preventive and early health care.

10.) Another example of unmet health needs in the Desire Project Area is the fact that on many occasions in the past three years children with diptheria were ad-

mitted to Charity Hospital. This disease is totally preventable and good programs of preventive medicine and health education could entirely eliminate such occurrances.

11.) It is also our experience at Charity Hospital that the instances of certain diseases among the poor such as tuberculosis and cervical cancer is higher than in the non-indigent population. With additional funds for further facilities Charity could construct outreach clinics, could expand its presently overcrowded outpatient and emergency facilities, and could add the additional needed beds to serve the needs of the metropolitan New Orleans area.

12.) On a recent inspection by the Joint Commission for Accreditation of Hospital, Charity Hospital was given a full two year accreditation. However, the major criticism of the site visit was the overcrowding of the inpatient and outpatient facilities of this institution.

/s/ Charles C. Mary, Jr., M.D.

Sworn to and subscribed before me
this 21st day of April, 1972.

/s/ [Illegible]
Notary Public

AFFIDAVIT OF RAYMOND DOWNS

STATE OF LOUISIANA

PARISH OF ORLEANS

I, Raymond Downs, being duly sworn, did depose and state as follows:

1. I am the Assistant to the Director of Charity Hospital of Louisiana at New Orleans.

2. On June 29, 1972, Dr. Max Kappleman, a third year resident in surgery at Charity Hospital gave to me a list of the record numbers of 50 patients. This was done at the direction of Dr. Rodrick Jaeger, Chief Resident, Tulane Surgery.

3. Upon the request of Marilyn G. Rose, attorney for the plaintiffs in *Cook* v. *Ochsner*, I directed Mrs. Eddie Cooksey, who is in charge of the record room at Charity Hospital to have someone under her supervision check the records of these patients to determine the condition for which each patient was waiting surgery and how long each patient had been so waiting.

4. The records were examined by extern Wayne Green and summaries are attached hereto and made part of this affidavit.

RAYMOND DOWNS

Sworn to and Subscribed before me
this —— day of July, 1972.

Notary Public

CHARITY HOSPITAL OF LOUSIANA

AT NEW ORLEANS

Progress Notes

T64-86139 Colostomy Stricture

In Med. Clinic Dec. 21, 1955—1st indications of rectum pains. Followed in Procto Cl Jan. 18, 1956 admitted for surgery.

Diagnosis—Adenocarcinoma of Rectum.

Operation—Abdominal perineral resection.

In Gen. Surgery Cl *Jan. 17, 1962*—diagnosis of colostomy stricture.

T62-6893 Breast Mass

In Gen. Surg. Cl *March 7, 1972* for evaluation of ® Breast Mass.

T63-34865 Gallstones

In Med Cl, *April 11, 1972*—it was noted that she had a history of gallbladder disease—symptomatic now. Has a gallbladder visualization on 5-24-72—impression cholelithiasis.

752-79575 Lipoma

In C704 10/24/52 with diagnosis of chronie ® humenis osteomyelitis.

In Ortho Cl *Oct. 9, 1961*—notation of lipoma on back.

T51-32918 Hernia

Seen in Acc Room on *4-13-72*—Diagnosis as Umbilical Hernia. In Gen. Surg. cl 4-27-72, diagnosis—same.

T51-32274 Lipoma

In Gen. Surg. Cl—*Sep. 10, 1951* with a diagnosis of lipoma of rt. flank. On 9/27/51 in Gen. Surg. Cl—had lipoma removed.

In Acc. Room *2/23/72*—diagnosis of lipoma of neck. In Gen. Surg. Cl 3/2/72—diagnosis as same.

665-102406 Anal fistula

On paper you had T65-102406—probably a wrong number. Patient had no diagnosis of anal fistula.

T65-99373 Gall Stones

On Jul. 15, 1953, patient had a normal cholecystogram. On 3/2/72 pt. had an oral cholesystogram with a diagnosis of cholelithiasis. In Med cl, *2/24/72*—had a oral GBU series, gallstones were in question.

T65-112872 Diverticulitis

In Gen. Surg. cl on *3/9/65*—had a Barium Enema—revealed diverticulae in caecum and transverse colon.

On 5/2/71—admitted to D710 for callus ft. Discharge Summary noted diverticulosis of sigmoid colon.

T66-125248 Colon Polyps

Pt. has been followed in cl since *1967* with possibility of colon polyps. He has been admitted for Ca of the prostate and has a history of Pagets disease.

T54-145198 Gall Stones

Pt. has been followed for transitional cell Ca of the ® kidney. Pt. had a cholecystogram done on 9/28/66 with a normal impression. In accident Rm on *6/5/72* with a diagnosis of choletithiasis. In general Surg. cl on 6/15/72 with same diagnosis.

T55-168252 Breast Mass

Pt. came to Accident Rm on *5/10/72* with a diagnosis of breast mass. Was in General Surg. cl on 5/18/72 with the same diagnosis.

T55-188727 Peptic Ulcer

Pt. has been followed from 1958 for pain in Right Upper Quadrant. Recently pt. was seen in Accident Room with a diagnosis of a possible peptic ulcer on *3/14/72*. Has been followed in Gen. Surg. and Ural. cl.

T68-190581 Lipoma

Pt. in General Surg. cl. on *4/6/72* with first diagnosis of lipoma.

T68-197061 Breast Mass

Pt. in Gen. Surg. cl on *3/9/72* what it states that a ® Breast mass was noted on Dec., 1971. Has been followed in clinic since.

T55-190970 Breast Mass

Complete chart in file.

Was in Gen. Surg. cl. on 7/9/71 for removal of popilloma from ® breast, no masses then.

In Gen. Surg. cl on *4/13/72*—notes that one month ago nodule found in Rt. Breast. followed in cl. since then.

T54-153922 Breast Mass

Pt. in Gen. Surg. cl *1/27/72* with a diagnosis of fibroadenoma of (L) Breast.

T45-180486 Breast Cyst

Complete chart not in file.

Pt. was in Acc. Room on *4/3/72* with a diagnosis of rt. breast tumor. In Gen. Surg. cl 4/6/72 diagnosis as rt. breast mass.

T55-190840 Lipoma

Pt. in Gen. Surg. cl on *4/13/72* for liposarcoma of back. Was admitted on 4/19/72 to W711 and lipoma was excised.

T68-191224 Breast Mass

Pt. referred from Family Planning with symptoms of small lump of L breast on *5/8/72*.

Seen in Gen. Surg cl. on 5/11/72 with diagnosis of ill defined L breast mass.

T70-232201 Hemorrhoids

Pt. was seen in Acc. Room on *12/2/71* and 12/3/71 with a diagnosis of external hemorrhoids. Was seen in

Procto Surg. cl on 12/13/71 with a dx of internal hemorrhoids.

T56-219256 Ganglion

Pt. was in Gen. Surg. cl 6/8/72. Was stated that pt. had a two month history of a cystic mass on the L foot. First noted on *6/1/72* when seen in Acc. Room.

T69-225105 Umbilical Hernia

Pt. was seen in Acc. Room *3/1/72* and 3/6/72 with same diagnosis of umbilical hernia. Was seen in General Surg. cl. with diagnosis of Umbilical hernia on 3/23/72.

T69-225837 Breast Mass

Pt. was seen in Gen. Surg. cl on *11/4/71* with a diagnosis of fibroadinoma of the ® breast.

T70-244780 Hernia

Pt. was seen in General Surg. Cl. on *5/6/71* with a diagnosis of vestical hernia.

T70-236335 Hernia

On *2/29/72* Pt. was seen in Acc. Rm. with a diagnosis of indirect inguinal hernia. Seen in Gen. Surg. cl on 3/2/72 with a dx of ® Femoral hernia.

T70-238488 Carotid Artery Stenosis

Admitted 1/21/71 with a dx of carotid artery stenosis. An carotid endarterctomy was performed. Was seen in Gen. Surg. cl on *4/22/71* with a dx of carotid stenosis.

T71-256190 Gallstones

Was admitted on *3/12/72* with a dx of Pancreatitis and cholecystitis. Has been followed in Gen. Surg. cl with a dx of cholecystitis.

T71-256898 Hernia

Pt. was in M.G.N. cl. on *4/16/71* with a dx of (L) Inguinal hernia. Admitted on 6-14-72 with the same diagnosis. An inguinal hernia repair was done. Discharged 6/19/72.

T71-261607 Lipoma

Pt. was seen in Ortho cl. on *1/3/72* with an accompanying dx of lipoma. Was in Acc. Room on 2/7/72 with same dx.

71-268369 Breast Mass

Pt. was sent from family planing with lump in (L) breast. Was seen in Gen. Surg. cl. on *9/20/71* with same diagnosis.

T57-276529 Breast Mass

Pt. was seen in Acc. Rm on *12/18/71* with dx as fibroadenoma. In Gen. Surg. cl on 1/13/72 with same dx.

T60-367578 Lipoma

Pt. seen in Gen. Surg. cl. on *2/10/72* with a clinical diagnosis of a lipoma on his back.

T72-284999 Colostomy Closure

Pt. was admitted on *2/14/72* to E408 with a dx of adenoiarcinoma of the colon. A colostomy was performed then. Pt. is being followed in Gen. Surg. Cl.

T72-287760 Breast Mass

Pt. was seen in Acc. Rm. on *3/13/72* with a dx of fibrocystic disease of both breasts. Seen in both General Surg. cl on 3/23/72—says pt. has masses in both breast for at least 4 months.

T71-278730 Breast Mass

Pt. seen in Gyn. cl. on *1/20/72* with a dx of fibroadenoma left breast.

T71-272453 Cholecystitis

Pt. was seen in Gen. Surg. cl. on *4/4/72* with a major dx. of cholecystitis. Pt. is blind and also a diabetic.

T50-423819 Gallstones

Complete chart not in file.

Pt. seen in Acc. Room on *5/4/72* with a dx of GB disease. Seen in Gen. Surg. cl on 5-16-72 and had a

GB visualization. There were some indication of gallstones. Had a cholecystogram with definite evidence of gallstones on 6-6-72.

T72-289206 Inguinal Hernia

Pt. seen in Gen. Surg. cl on *2/10/72* with a dx of ® inguinal hernia. Admitted on 4/12/72 to E807 with a dx of ® inguinal hernia and benign prostrate hypertrophy. Admitted on 5/15/72 with a dx of ® inguinal hernia and Upper GI Bleeding. An inguinal hernia repair was done.

T59-318681 Hemorrhoids

Pt. seen in Gen. Surg. cl. on *3/2/72* with a dx of hemorrhoids.

T48-327652 Lipoma

Pt. seen in Gen. Surg. cl. on *8/21/71* with a dx of a large lipoma.

T72-287747 Colon Cancer

Pt. seen in Acc. Rm. on *3/21/72* with a dx of R/O Ca Colon. Pt. admitted on 5/2/72 to W711 with a dx of benign adenomatous colonic polyp.

T61-385555 Varicose Veins

Complete chart not in file.

Pt. admitted to Obst ward on *5/3/72*. During P.E. varicose veins were noted.

T72-294236 Hemorrhoids

Pt. came to Acc. Rm. on *6-19-72* with a dx of external hemorrhoids. Pt. was seen in General Surg. cl. on 6/22/72 with a clinical dx of external hemorrhoids.

T72-287752 Breast Mass

Pt. seen in Acc. Rm. on *3/21/72* with a diagnosis of a L Breast mass. In Gen. Surg. cl on same date with dx of fibroadenoma of L breast.

T72-286883 Breast Mass

Pt. was seen in General Surg. cl on *4/6/72* with a dx of breast mass in both R & L.

M C of L65-91906 Hemorrhoids

Probably wrong number.

T51-23729—no chart in file. Lipoma

EXHIBIT 15

HEALTH INSURANCE INSTITUTE

277 Park Avenue, New York, New York 10017

March 1, 1973

Mr. Mal Schechter, Senior Editor
Hospital Practice for the Staff
and Community Physician
1230 National Press Building
Washington, D.C. 20004

Dear Mr. Schechter:

This is in reply to your questions about the *1972-73 Source Book of Health Insurance Data.*

The hospital, surgical, regular medical, and short-term disability income coverage figures were revised for 1965-1970 in the 1972-73 *Source Book.* This revision was noted in the text on page 17 and in the footnotes of each table that appears in the book.

In answer to your second question about benefits to coverage ratio for insurance companies versus Blue Cross, Blue Shield, insurance companies offer a wider choice of benefit patterns to employes and individuals than Blue Cross, Blue Shield. Insurance company plans are as broad, and broader than Blue Cross, Blue Shield but many are smaller, and it depends on the purchaser of the plan and his needs. Smaller payments bring the average size payment down in size.

Out hospital expense benefits for daily hospital room and board are for group in force. Group insurance coverage represents 74% of all insurance coverage. Some of these people also have individual coverage. Some 27% of employees covered under basic hospital expense

policies with no supplementary major medical policy had under $25 coverage of the ward or semi-private daily hospital room and board rate. There were 10% with supplementary major medical.

Some 58% had $50 and over coverage under basic hospital expense policies with no supplementary major medical policy; 49% had it with supplementary major medical.

Please let us know if you have any other questions.

Sincerely,

/s/ Rosemarie Shomstein
Rosemarie Shomstein
Senior Research Assistant

RS:sll

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[Title Omitted]

STATEMENT OF MATERIAL FACTS
NOT IN DISPUTE

[dated April 10, 1973]

1. The Internal Revenue Code of 1954 provides certain tax benefits and exemptions for institutions classified under the provisions of the Code as "charitable," to wit: institutions which qualify as charitable are exempted from payment of Federal income taxes by virtue of 26 U.S.C. 501(c)(3); contributions to such institutions are deductible from gross income on individual and corporate income tax returns by virtue of 26 U.S.C. 170(a) through (c); such institutions and donors to such institutions are also eligible for other Federal tax benefits and advantages under Section 642(c), 2055, 2106 (a)(2) and 2522 of 26 U.S.C.

2. As of 1970 there were 3,386 nongovernmental not-for-profit short-term general and other special hospitals in the United States. (*Hospitals*, Journal of the American Hospital Association, Guide Issue, Part II, August 1, 1971, p. 462). These hospitals are eligible to claim charitable status under the provisions set forth in paragraph 1, file the pertinent forms claiming such eligible status, and be determined as such by Defendants or their agents. A substantial number, if not all, of these hospitals do in fact claim such status, pay no taxes and their donors deduct contributions to them under the provisions set forth in paragraph 1.

3. The amount of monies which otherwise would be taxable as income to such hospitals or which otherwise

could not be deducted from taxable income by donors to such hospitals is substantial. Representative of the current amount of monies so affected are the following figures for 1969:

—In 1969 hospitals received some $2.3 billion as charitable contributions (Hearings on Medicare and Medicaid before the Subcommittee on Medicare-Medicaid of the Senate Committee on Finance, 91st Cong., 2nd Sess. 422 (1969).

—In that same year net income for all nonprofit community hospitals was $400 million. (*Net Income of Hospitals*, 1961-1969, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, Staff Paper No. 6, p. 27). Except for 501(c)(3) and 170(c) status as "charitable" institutions, such monies would have been taxable in accordance with applicable provisions of the Internal Revenue Code.

4. Until the issuance of Revenue Ruling 69-545 (1969 Cum. Bull.), successive Commissioners of Internal Revenue had always followed the legal interpretation and policy that hospitals had to afford services to persons unable to pay in order to be eligible for status of "charitable" institutions under the Code.

5. In 1956 the Internal Revenue Service issued Revenue Ruling 56-185, which "codified" the position which it, and the courts, had taken with respect to the obligations of a "charitable" hospital to serve the poor. That Ruling stated in part that in order for a private hospital to establish that it qualified as a charity pursuant to Section 501(c)(3),

> "it must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able to pay. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered." Rev. Rul. 56-185, 1956-1, C.B. 202, 203.

6. In 1969 the original Defendants in this action issued Revenue Ruling 69-545, 1969 Cum. Bull., which in pertinent part provided:

> "In order for a hospital to establish that it is exempt as a public charitable organization under § 501 (c)(3) it must . . . be operated for the care of all those persons in the community able to pay the cost therefor either directly or through third party reimbursement."

In said ruling said Defendants specifically reversed Rev. Ruling 56-185 that a charitable hospital within the meaning of the Internal Revenue Code must not refuse to accept patients in need of hospital care who cannot pay for such services. The present Defendants have continued to follow such position and to permit hospitals the benefits of the provisions set forth in paragraph 1 without requiring them to serve persons unable to pay.

7. Revenue Ruling 69-545 was issued on October 8, 1969 without a notice of proposed regulations, and with-

out an opportunity for interested and/or affected parties to present their views, arguments, and opinions, and to assert facts, positions of policy, and positions of law to the original Defendants in this action. Present Defendants have continued such policies and have not afforded interested and/or affected parties any such opportunity.

8. Defendants did not follow the procedures set forth in section 553 of the Administrative Procedures Act for rule-making.

9. On May 22, 1971 a Notice of Hearing on proposed amendments to the regulations under section 170 of the Internal Revenue Code, relating to charitable contributions, appeared in the Federal Register, Vol. 36, No. 100. Individual Plaintiffs Henry and Carolyn Block, Monica Hunter, Rosezella Cook, and Shirley Lampton, and organizational Plaintiffs Eastern Kentucky Welfare Rights Organization, California Welfare Rights Organization, and National Tenants Organization, among others, filed a Statement on the definition of "charitable" hospitals under section 170 of the Internal Revenue Code, with attachments, a copy of which is attached to the Motion for Summary Judgment as Exhibit 2. On June 22, 1971, said individual and organizational Plaintiffs, represented by their counsel, Anthony Z. Roisman, testified before a hearing panel established to hear testimony under said proposed rule-making. Mr. Roisman, as set forth more fully in his Affidavit, attached to the Motion for Summary Judgment as Exhibit 3, was told that the subject of the hearing did not pertain to the matters which he raised, and that his testimony and the matters set forth in Exhibit 2 were addressed to the wrong forum.

10. Among the hospitals eligible for charitable status under the provisions of the Internal Revenue Code described in paragraph 1, and which have been accorded such status, are the following:

(a) In New Orleans, Louisiana: Roman Catholic Sisters of Mercy, Southern Baptist, Methodist Hospital, Hotel Dieu Sisters Hospital, Ochsner Foundation Hospital, Flint-Goodridge Hospital of Dillard University, Sara Mayo Hospital;

(b) In Tucson, Arizona: Tucson Medical Center;

(c) In Floyd and Pike Counties, Kentucky: Prestonburg General Hospital (legally known as Highland Hospital Corporation) and Methodist Hospital of Pikesville.

11. Individual Plaintiffs and persons who are members of and represented by organizational Plaintiffs are all persons who are unable to pay for hospital services, and some, if not all, needed such services at various times relevant hereto. (Affidavits attached to Motion for Summary Judgment).

12. "On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses, their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and non-white children, millions of whom receive little or no dental or pediatric care." *Towards a Comprehensive Health Policy for the 1970's, A White Paper*, U.S. Department of Health, Education, and Welfare, May 1971, p. 2.

Date: April 10, 1973

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil No. 1378-71

[Title Omitted]

CROSS MOTION FOR SUMMARY JUDGMENT

[Filed June 27, 1973]

Comes now the defendants herein by their attorneys and move this Court for an order denying plaintiffs' motion for summary judgment and granting summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure in favor of the defendants, George P. Shultz, Secretary of the Treasury, and Donald C. Alexander, Commissioner of Internal Revenue for the following grounds:

1. The plaintiffs lack standing to maintain this action;

2. The actions complained of herein are not subject to review by this Court;

3. The plaintiffs have failed to demonstrate that the alleged injuries complained of herein were incurred as a result of any actions on the part of the defendants.

/s/ John J. McCarthy—by JBT
JOHN J. MCCARTHY
Chief
General Litigation Service
Tax Division
Department of Justice
Washington, D.C. 20530

/s/ Jack B. Teplitz
JACK B. TEPLITZ
Trial Attorney
Tax Division
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APPENDIX A

AMERICAN HOSPITAL ASSOCIATION
Washington Service Bureau
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Cable Address: AMERHOSP

STATEMENT OF
JOHN ALEXANDER McMAHON
PRESIDENT OF
THE AMERICAN HOSPITAL ASSOCIATION
ON TAX REFORM
BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS

April 13, 1973

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association which represents some 7000 hospitals throughout the country. Accompanying me is Leo J. Gehrig, M.D., the Association's Vice President for Federal Relations. I appear today to express to the Committee our concern with any action the Committee might take in connection with its current consideration of tax reform, which could jeopardize or in any way inhibit charitable contributions to the nation's voluntary nonprofit hospitals.

In ours as well as in other civilized societies the hospital is the primary instrument developed for the care of the sick and is the community center of health care. Nations have met their obligation with respect to the development of hospital facilities and hospital care in different ways. Some have developed systems which, from the beginning, have been the complete responsibility of the government. The government builds the hospitals,

operates them, and appropriates tax funds to pay for their operation. Nothing is left to the voluntary efforts of individuals. However, in the United States, a pluralistic approach has been utilized which supports the development of the voluntary nonprofit hospital.

In our publication, *Hospital Statistics, 1971*, 5,865 institutions out of a total registered hospital population of 7,097 institutions are identified as community hospitals. Of the 5,865 community hospitals, 3,363, or 57.3 percent are voluntary nonprofit hospitals. These nonprofit hospitals, while representing only 57 percent of all community hospitals, nevertheless have 70 percent of the total community hospital beds. In 1971 they admitted more than 21 million persons for inpatient care, or 71 percent of all admissions to community hospitals in the nation. Moreover, they provided services through more than 100 million outpatient visits, 70 percent of the total outpatient care provided by community hospitals. These statistics show conclusively that the nonprofit voluntary hospital is the backbone and strength of our community hospital system.

Voluntary nonprofit hospitals are, in varying degrees, dependent upon charitable contributions made by a generous public. Most were originally organized and constructed, partially or totally, through such resources. And they have continued to rely on charitable contributions in meeting the costs not only of construction and equipment but also in the financing of research, education, and general operations which have become increasingly expensive.

Only four years after the initial enactment of the first income tax act, the Congress recognized that the charitable contribution removed a burden from government. This recognition resulted in an encouragement to the generous impulses of society by giving individuals a

deduction from taxable income for their support of religious, charitable and educational activities. Until recent years, the changes in income tax provisions were in the direction of further encouragement to these benefactors of the community rather than moves to discourage their philanthropic impulses.

Section 170 and 501(c)(3) of the Internal Revenue Code are recognition on the part of the Federal government that nonprofit hospitals render a substantial benefit to the community in making hospital facilities and services available as a function in the public interest which would otherwise have to be fulfilled by government at tax expense. A basic incentive to the donations spelled out in the IRS Code are tax benefits and income tax deductions which have been granted by the states since the inception of the Republic and by the Federal government following the enactment of the Federal income tax laws.

Fundamentally, such provisions in the law arose from public needs and the public's recognition of the essential function of the voluntary nonprofit hospital. The public also recognized in supporting such laws that hospital service was an essential function which must be discharged, if not by voluntary agencies, then by government.

The charitable deduction is not a loophole. It differs from most other deductions and tax preferences in that it is not economically motivated. Other deductions inure to the individual taxpayer's benefit. However, the donor would be economically ahead by not making a charitable gift because the tax savings would always be less than his contribution. Charitable contributions are voluntary and benefit the nation as a whole. Any reduction of current incentives to charitable contributions or a transfer tax on a gift or a bequest to charity would, in

effect, be an indirect tax on publicly supported charitable organizations.

Moreover, voluntary charitable contributions have offered the means of maintaining the historical balance between government services and voluntary initiatives. The charitable contribution deduction enables citizens to participate in making decisions rather than to concentrate greater power in government.

We also believe strongly that existing tax preferences for such donations are the single most important incentive for people to continue to support charitable enterprises. In a recent decision * involving tax preferences, Judge Edward Allen Tamm of the United States Court of Appeals for the District of Columbia made the point that the tax deduction motivates charitable contributions. We think this is self-evident.

We recognize, of course, that the Committee is considering a number of proposals that would revise the system of tax preferences for charitable contributions for various reasons, including a more equitable distribution of the tax preference and a more efficient administration of the tax laws. However, we believe the present partnership relation between government and the private sector is clearly advantageous to the Federal government and should be retained.

In the document entitled "Giving, U.S.A.," the American Association of Fund-Raising Counsel, Inc., has compiled facts and cited trends in American philanthropy for the year 1971. That Association's computations disclose that during 1971 total charitable giving came to $21.15 billion, of which $3.4 billion was donated to the health and hospital field. Significantly, 71.4 percent of this total giving came from individuals.

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* "Americans United" Inc., et al v. Commissioner of Internal Revenue, No. 71-1299, January 11, 1973.

We have recently surveyed 3,530 voluntary nonprofit hospitals located in the United States. At an initial cut off of returns in order to provide you with statistics at this time, a total of 891 responses, just over 25 percent, were received. These 891 institutions reported total voluntary support of $181 million in 1972. A projection of this initial response arithmetically over the entire field, would indicate one year's contributions to voluntary nonprofit hospitals of about $800 million. Approximately 70 percent of this amount represents outright gifts, the remainder being divided, 25 percent from bequests and 5 percent from deferred gifts. Further, more than half of the total amount represents contributions by individuals.

If this source of funds were to disappear from the hospital financing picture, it would have to be replaced. I think it is obvious where the hospital field would have to go for that replacement—government and hospital patients. In the interim, after the voluntary source of funds had disappeared and until the government could recognize its obligation to replace them, serious hardships would occur among the patient population in hospitals and to the hospital service industry. To the extent that these funds are used for capital purposes, modernization or construction to meet the demands of changing technology and needs, such efforts would grind to a sudden halt. Where these funds are used to meet operating costs, the costs of education, research or the application of new technology, such programs would also be dangerously impaired.

According to 1970 IRS statistics, of the 35.5 million taxpayers who itemized deductions, 29 million deducted 3 percent or less for charitable contributions. These deductions totaled $10.56 billion, or 82 percent of all itemized and individually contributed dollars. Thus, 29 million out of 35.5 million taxpayers would have no income tax

incentive for their contributions if, as has been suggested, a 3 percent floor provision were to be enacted. Such a provision, we believe, would be a disincentive for taxpayer contributions, requiring that other sources fill the breach.

One proposal would disallow the charitable contribution as a deduction in determining the taxable income, but would allow every taxpayer a tax credit of 24 percent of a contribution. For the taxpayer in an income bracket with a tax liability in excess of this tax level, the proposal would certainly discourage contributions. The effect on the generous impulses of the taxpayer in the higher bracket would be the same as the three percent floor. And since the net economic cost to him would be greater, fewer dollars would be contributed.

Another concept for change would place a ceiling of 50 percent on a charitable contribution which could be deducted for the purposes of computing the Federal estate tax. Under the present law, the charitable deduction for estate tax purposes is without restriction. Referring again to our survey of 3,530 voluntary nonprofit community hospitals, the responding institutions reported that some $45 million came through bequests from testators. If a 50 percent ceiling had been in effect at the time these wills were drawn, there can be little question that the $45 million would have been substantially less. Therefore, this concept, like the foregoing proposal, could only add to the financial burdens of the government and the paying patients.

In this connection I would like to call to the attention of the Committee the conclusion reached by the American Law Institute, that:

> "The 100 percent charitable deduction in the field of transfer taxation should be retained, under either a dual tax system or a unified tax."

To impose a gift tax on a transfer to charity would be to discourage giving to charity which is directly contrary to the long-standing policy of Congress to encourage contributions through the income and estate tax deduction.

A proposal which has been made in times past and no doubt will again be considered would be to change the rules with respect to the deductibility of gifts of appreciated property. This type of gift is of prime importance to many charities and is of significant interest to the hospital field. Again referring to the survey which the Association made recently, the 891 responding hospitals reported non-cash gifts totaling almost $26 million. It is safe to say that in many instances non-cash gifts represented gifts of appreciated property. While it is not always possible to know the tax status of the donor from the records of an institution, we certainly may assume that a gift made other than cash serves a purpose of the donor. Most likely that purpose would be the added tax incentive which he receives as a result of the appreciation in the property donated. Thus, a change in provisions with respect to the deductibility of gifts of appreciated property, just as would be true for the two examples I've already cited, would only result in another disincentive to charitable contributions. And on this basis such a proposal would be opposed by hospitals. Moreover, we believe that *any* deterrent to charitable giving would be contrary to the public interest and detrimental to the capability of voluntary nonprofit hospitals to provide public service.

Hospitals provide an indispensable public service. This service has become more imperative with the recognition that health care is an inherent right of all persons. Demands on hospitals, as a result, can only continue to increase as we strive to make their services more accessible to everyone in a growing population. Our hospital system—by public preference—continues to be financed

through multiple sources and includes varied forms of delivery of health services. But voluntary nonprofit hospitals predominate. These nonprofit institutions must rely on numerous sources of financing, many of which fail to meet the totality of costs. Thus, a vital component of nonprofit hospital financing continues to come through the charitable contributions of concerned citizens.

Any decrease in voluntary gifts will force such hospitals to increase their charges to all patients and the government for its beneficiaries in programs such as Medicare and Medicaid. And it is our feeling that any such increase in charges will in many instances result in a limitation on service to the public by placing hospital care beyond the financial reach of many persons. This is why we request that your Committee support provisions that would strengthen rather than inhibit incentives for voluntary gifts. Such contributions are essential to community service.

Mr. Chairman, we appreciate the opportunity to present the views of the hospital field to the Committee and would be pleased to answer any questions which the Committee members may have.

[Emblem]

AFFIDAVIT

The information indicated below applies to fiscal year July 1, 1972, through June 30, 1973.

Number of indigent patients treated free or part pay in the Emergency Department:	32
Number of indigent in-patient admissions with care on a free or part pay basis:	68
Total number of patients, including the indigent, Emergency Department:	12,098
Total number of in-patient admissions, including the indigent:	6,767

Noted:

The records as pertains to the number of indigent, free and part pay cases, were commenced in November, 1972; theretofore, no statistics were maintained on these patients.

The number of indigent, free and part pay cases, treated during the period of this report may increase as circumstances become known and occasion reclassification.

/s/ Paul A. Bjork
PAUL A. BJORK
Executive Director

Sworn to and Subscribed before me
this 17 day of July 1973

/s/ Charles E. McHale, Jr.
Notary Public

METHODIST HOSPITAL

5620 Read Road—New Orleans, Louisiana 70127
Telephone (504) 241-2400

Office of the Administrator

W. E. Elliott, President
Board of Directors

THE METHODIST HOSPITAL OF KENTUCKY

INCORPORATED

Pikeville, Kentucky

ALL AMERICA CITY

July 13, 1973

Office of Chief Counsel
General Litigation Division
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Personal Attention of: John B. Cummings
Room 4242

I, Lee D. Keene, Administrator of the Pikeville Methodist Hospital, do hereby certify that the following information is true and correct to the best of my knowledge and belief.

1. Unable to provide specific information concerning the number of patients treated by the hospital for free in the emergency room.
2. Unable to provide specific information concerning the number of patients treated by the hospital on a reduced charge basis in the emergency room.
3. Twenty-four (24) patients were treated by the hospital for free on a regular admission basis.
4. 2,310 patients (1,542 Medicare—768 Medicaid) were treated by the hospital on a reduced charge basis on a regular admission basis.
5. 15,386 patients were treated by the hospital in the emergency room.

6. 8,110 patients were treated on a regular admission basis.

The above information is furnished for the fiscal year ended September 30, 1972.

/s/ Lee D. Keene
LEE D. KEENE
Administrator

Subscribed and sworn to before me by Lee D. Keene, this 13th day of July 1973.

/s/ [Illegible]
Notary Public
Kentucky State at Large

My commission expires 4-15-74

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil No. 1378-71

[Filed Feb. 22, 1974]

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Plaintiffs

v.

GEORGE P. SHULTZ, ET AL.,
Defendants

NOTICE OF APPEAL

Notice is hereby given that the defendants hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from the order and judgment entered in this action on January 29, 1974, granting plaintiffs' motion for summary judgment, and denying defendants' motion for summary judgment, and issuing an injunction against defendants.

Respectfully submitted,

February 22, 1974

/s/ John J. McCarthy
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DONALD J. GAVIN
MILAN D. KARLAN
Attorneys
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Department of Justice
Washington, D. C. 20530

Of counsel:

HAROLD H. TITUS, JR.,
United States Attorney

CERTIFICATE OF SERVICE

It is hereby certified that service of this appendix for the appellants has been made on the appellees, by and through their counsel of record, by mailing four copies thereof on this —— day of April, 1974, in an envelope, with postage prepaid, properly addressed to him as follows:

Irving Weiser, Esquire
c/o Biltmore Hotel
5th & Olive Streets
Los Angeles, California 90013

SCOTT P. CRAMPTON
Assistant Attorney General

GENERAL DOCKET

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

74-1293

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

v.

WILLIAM E. SIMON, ET AL., Secretary of Treasury,
Appellants

APPEAL FROM THE DISTRICT COURT

Attorneys for Appellant

U.S. Dept. of Justice, 20530:

Scott P. Crampton, 739-2951
Leonard J. Henzke, Jr., 739-2933
Wesley J. Filer, 739-3026
Philip L. Brennan, 739-3026

Pro Hac Vice:

Leonard J. Henzke, Jr.
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American Hospital Assoc., movant for leave to file brief as amicus curiae:

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500 Southern Building, 20005

Attorneys for Appellee

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1751 N Street, N.W., 20036

No. below: Civil Action 1378-71

Judge below: Barrington D. Parker

Date of Judgment: January 29, 1974

Notice of appeal filed: February 22, 1974

DATE	FILINGS—PROCEEDINGS
(L)2-26-74	Certified Original Preliminary Record (no transcript)
(G)2-26-74	4-Appellants' motion for stay of injunctive relief (m-26)
(G)3-6-74	4-Appellees' opposition to motion for stay (m-6)
(G)3-6-74	4-Motion of American Hospital Association for leave to file brief as amicus curiae, participate in oral argument and to file memorandum in support of stay (m-6)
(G)3-11-74	4-Appellants' reply to opposition to motion for stay (m-11)
(G)3-12-74	4-Appellees' response to motion by American Hospital Association for leave to file brief as amicus curiae and to participate in oral argument (m-11)
(G)3-14-74	4-Appellees' reply to opposition to motion to stay (m-14)
(G)3-14-74	4-Appellants' supplemental memorandum in support of motion for stay (m-14)
(M)3-21-74	4-Request for expedited consideration of Appellants' motion for stay (m-21)
(M)3-26-74	Per Curiam order granting the motion for leave to file brief as amicus curiae; the motion to participate in oral argument is denied without prejudice to its renewal before

DATE	FILINGS—PROCEEDINGS
(M)3-26-74	the division of the Court assigned to hear this case on the merits; the Clerk is directed to file the memorandum in support of stay of amicus curiae; the motion for stay is denied; the parties to this appeal are directed to submit to the Court, by April 10th, an expedited briefing schedule which provides for the filing of final briefs no later than May 6, 1974; the Clerk is directed to schedule this case for argument during the May/June sitting period of the Court; Fahy, Sr. CJ and Robinson, CJ
(M)3-26-74	4-Memorandum of American Hospital Asso. in support of motion for stay
(G)4-1-74	4-Appellees' motion for leave to file joint briefing schedule seeking additional time to file briefs (m-1)
(G)4-2-74	Certified Original Record 2 volumes (no transcript) (n) 5-16
(B)4-5-74	Clerk's order directing Clerk to file joint motion for briefing schedule and further ordered that the following schedule shall apply: Appellant's brief—April 17th; Appellees' brief—May 13th; Reply brief, if any,—May 17th
(B)4-5-74	4-Joint briefing schedule of parties (m-1)
(G)4-17-74	25-Brief of American Hospital Association as amicus curiae (p.17)
(G)4-17-74	4-Appellants' motion for leave to file opening brief which exceeds the length allowed by Rule 28(g) of the FRAP and temporarily to file typewritten copies of the brief (OK HK) .(m-17)
(I)4-19-74	10-Joint Appendix, (m-17)

DATE	FILINGS—PROCEEDINGS
(B)5-7-74	Clerk's order directing Clerk to file appellant's brief in excess of page limitation
(B)5-7-74	7-Appellant's typewritten brief (m-17)
(B)5-7-74	25-Appellant's printed brief (m-29)
(B)5-8-74	Clerk's order sua sponte, that the following times will be allotted for oral argument in this matter: Appellants—20 minutes Appellees—20 minutes
(L)5-13-74	4-Appellees' motion for leave to file temporarily typewritten copies of brief (p-13)
(M)5-14-74	Clerk's order granting appellees' motion for leave to file temporarily typewritten copies of the brief
(M)5-14-74	7-Appellees' brief (p-13)
(B)5-15-74	4-Motion of amicus curiae American Hospital Assoc., for leave to participate in oral argument (m-14)
(G)5-16-74	4-Appellees' opposition to motion by The American Hospital Association to participate in oral argument (m-16)
(G)5-17-74	25-Appellees' brief (m-17)
(M)5-21-74	Clerk's order denying motion of amicus curiae American Hospital Asso. for leave to participate in oral argument
(G)5-21-74	Letter from appellants advising of additional authorities pursuant to local Rule 8(g)
(G)5-21-74	4-Appellants' motion to substitute party (m-17)
(G)5-21-74	25-Appellants' reply brief (m-17)

DATE	FILINGS—PROCEEDINGS
(M)5-22-74	Clerk's order granting appellants' motion to substitute party and the Clerk is directed to remove the name of George P. Shultz as an appellant and to substitute therefor the name of William E. Simon
(G)5-28-74	4-Appellees' motion for leave to file supplemental brief (m-28)
(B)5-31-74	Clerk's order granting appellees' motion for leave to file a supplemental brief and Clerk is directed to file aforesaid brief
(G)5-31-74	15-Appellees' supplemental brief (m-28)
(M)6-12-74	Argued before Wright and Wilkey, CJ and William J. Jameson, U.S. Sr. District Judge for the District of Montana, sitting by designation; On motion by Leonard J. Henzke, Jr., Wesley J. Filer a member of the bar for the Supreme Court of Texas was allowed to argue pro hac vive for appellant's
(B)7-8-74	1-Letter from counsel for appellant informing Clerk of additional authorities pursuant to Local Rule 8 (g)
10-9-74	Opinion for the Court filed by Senior District Judge Jameson.
10-9-74	Opinion concurring in part and dissenting in part filed by Circuit Judge Wright.
10-9-74	Judgment reversing judgment of the District Court. (n)
(G)10-15-74	1-Appellants' Bill of Costs (m-11)
(G)10-23-74	25-Appellees' petition for rehearing and/or suggestion for rehearing en banc (m-23)
12-6-74	Per Curiam order denying appellees petition for rehearing.

DATE	FILINGS—PROCEEDINGS
12-6-74	Circuit Judge Wright would grant rehearing for the reasons set forth in his statement as to why he voted to grant rehearing en banc.
12-6-74	Per Curiam order denying suggestion for rehearing en banc.
12-6-74	Statement of Chief Judge Bazelon with whom Circuit Judges Wright and Robinson concur, as to why he voted to grant rehearing en banc.
12-6-74	Statement of Circuit Judge Wright, with whom Chief Judge Bazelon and Circuit Judge Robinson concur as to why he voted to grant rehearing en banc.
12-17-74	Copy of opinion of 10-9-74 and 12-6-74 on rehearing and certified copy of judgment and bill of costs in the amount of $279.35 issued to the District Court.
(B)2-26-75	4-Appellees' motion for transmittal of certified original record to the Supreme Court (m-2-)
(B)3-7-75	Notification of filing a petition for certiorari in the Supreme Court on March 6, 1975 in no. 74-1110
(R)3-11-75	Order per CJ Bazelon granting motion for transmittal of certified record to the Supreme Court
(G)3-12-75	Notification of filing a petition for certiorari in the Supreme Court on March 8, 1975 in No. 74-1124
(P)4-1-75	Certified record of pleadings, etc. prepared and hand delivered to Supreme Court.

DATE	FILINGS—PROCEEDINGS
(R)4-1-75	Certified copy of the order of 3-11-75 and the Certified Preliminary Record and the Certified Original Record 2 vol. sent to Clerk, U.S. Supreme Court
(R)4-1-75	Receipt returned from Clerk, U.S. Supreme Court for Certified Preliminary Record and the Certified Original Record 2 vols.
(C)5-27-75	Certified copy of order from Supreme Court granting petitions for writs of certiorari in Nos. 74-1110 & 74-1124.

SUPREME COURT OF THE UNITED STATES

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.,
Petitioners

v.

WILLIAM E. SIMON, Secretary of the Treasury, ET AL.

ORDER ALLOWING CERTIORARI

Filed May 19, 1975

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted. This case is consolidated with No. 74-1124 and a total of one hour is allotted for oral argument.

SUPREME COURT OF THE UNITED STATES

No. 74-1124

WILLIAM E. SIMON, Secretary of the Treasury, ET AL.,
Petitioners

v.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, ET AL.

ORDER ALLOWING CERTIORARI

Filed May 19, 1975

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted. This case is consolidated with No. 74-1110 and a total of one hour is allotted for oral argument.